Table of Contents

State/Territory Name: Arizona

State Plan Amendment (SPA) #: 13-0005-MM

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 30, 2013

Tom Betlach, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

Enclosed is an approved copy of Arizona's state plan amendment (SPA) 13-0005-MM, which was submitted to CMS on July 8, 2013. SPA 13-0005-MM incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Arizona's Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0005-MM includes full approval of your alternative single streamlined application – both the paper and online versions.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the back of Arizona's approved state plan:

- S94, pages 1-2
- Attachment 1 - Alternative single, streamlined paper application: Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)/Arizona Health Care Cost Containment System (AHCCCS Application for Help with Health Coverage Costs, AH-001 (10/13)
- Attachment 2 - An alternative paper application for multiple human service programs, including health insurance, SNAP and TANF: Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)/Arizona Health Care Cost Containment System (AHCCCS) Combined Application for Benefits, FA-001 (10/13)
- Attachment 3 - Health–e-Arizona Plus Medical Application Roadmap
- Attachment 4 - Health–e-Arizona Plus Online Flow Chart
- Attachment 5 - Key Differences between the Health–e-Arizona Plus online application and the CMS online application
- Attachment 6 - Statement regarding Agreements Related to Coordination of Eligibility and Enrollment

In addition, the following current state plan pages have been superseded by SPA 13-0005-MM and reserved in the State Plan:

- Section 2, Page 10, section 2.1(a), TN # 92-4, effective date: 1/1/92, approved: 6/2/92
- Section 2, Page 11a, section 2.1(d), TN # 92-4, effective date: 1/1/92, approved: 6/2/92

Please note that the HHS Office for Civil Rights (OCR) has an open civil rights investigation in Arizona to resolve complaints filed under Title VI of the Civil Rights Act. During the course of its investigation, OCR has identified compliance concerns with Arizona's Medicaid forms and procedures for processing Medicaid applications. CMS' review of Arizona's State Plan amendment and proposed forms, in lieu of using the CMS Model Single Streamlined Application, was limited to an analysis of compliance with applicable Medicaid laws and regulations. Because compliance with Federal civil rights laws is also a condition of receipt of Medicaid funding, however, HHS OCR also reviewed Arizona's forms in the context of its Title VI investigation and we sent comments to the state on behalf of OCR on August 9, 2013. HHS OCR officials met with Arizona State officials to discuss resolution measures on August 12, 2013 and CMS is happy to provide technical assistance about Medicaid issues during the course of any subsequent discussions. Both CMS and HHS OCR are committed to working together with Arizona to meet the deadlines under the Affordable Care Act to assist the State of Arizona in being ready to launch Marketplace options in a way that ensures that both Medicaid and civil rights issues are addressed.

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan amendment. If you have any questions concerning this SPA, please contact Rebecca Bruno at 415-744-3677, or by e-mail at Rebecca.Bruno@cms.hhs.gov.

Sincerely,

/s/
Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Wakina Scott
HeeYoung Ansell

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Arizona

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AZ-13-0005

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	14	$96550800.00
Second Year	15	$125606400.00

Subject of Amendment

Arizona State Plan Amendment to include the General Eligiblity Requirements; Eligibility Process S94 information in the State Plan.

Governor's Office Review

- (●) **Governor's office reported no comment**
- (●) **Comments of Governor's office received**

  Describe:
- (●) **No reply received within 45 days of submittal**
- (◉) **Other, as specified**

  Describe:
  Governor's Office is aware.

Signature of State Agency Official

Submitted By: **Theresa Gonzales**

Date Submitted: **Sep 30, 2013**

DATE RECEIVED:	DATE APPROVED:
7/8/2013	9/30/2013
PLAN APPROVED – ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL:	SIGNATURE OF REGIONAL OFFICIAL:
10/1/2013	[redacted]
TYPED NAME	TITLE
Gloria Nagle	Associate Regional Administrator

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	An individual can fax an application to the Medicaid or Human Services Agency	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: Arizona

Reserved

Revision: HCFA-PM-91-8 (MB) OMB No.
October 1991

State/Territory: Arizona

Reserved

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

Application for Help with Health Coverage Costs

AHCCCS Medical Assistance, Help with Medicare Costs, and Tax Credits to help pay premiums

Tear off and keep pages A through D for your records.

What is this application for?

Use this application to see if you and your family qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- A new tax credit that can help pay your health insurance premiums

Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your family members. You can use this application to apply for anyone in your family, even if they already have insurance.

Your family includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance)
- People you claim on your income tax return even if they do not live with you
- Relatives in your care who are under the age of 19 and live with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

Where else can I apply?

You can apply faster online at: www.healthearizonaplus.gov

You can fill out this application and turn it in by mail, fax or in person to any local or any Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or you can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?

You may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your family
- Information for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for so much information?

We ask about income and other information to make sure you and your family get the correct benefits.

We will keep all information you provide private, as required by law.

What happens next?

Send your completed, signed application to the address on page 14 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov
Phone: 1-855-HEA-PLUS (432-7587)
In person: Visit www.azdes.gov/faa or call 1-855-HEA-PLUS (432-7587) to find the office closest to you

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona's Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication*
- Doctor's Office Visits**
- Laboratory and X-ray Services
- Hospital Services
- Dialysis
- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots)
- Chemotherapy
- Emergency Medical Care
- Rehabilitation Services
- 90 days of nursing care services

* AHCCCS prescription coverage is limited for people who have Medicare.
** Wellness visits for people age 21 and over are not covered.

What is Medicare Savings Program?

Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare Part B premium
- Medicare deductibles and copayments
- Automatic Extra Help for Medicare Part D prescription expenses

What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

Do I need a Social Security number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance or help with Medicare costs (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have a Social Security number (SSN), we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

We use your information, including Social Security number, to:

- Verify identity
- Verity citizenship and immigration status
- Verify income
- Prevent duplicate benefits
- Collect money we overpaid you in the form of benefits
- Computer match with state, local and federal agencies and our other programs to verify information
- Share with other government agencies and their contractors to assess program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

Do I have to give information about my citizenship and immigration status?

- To get the most AHCCCES Medical Assistance benefits and/or help with Medicare costs, you need to give us information about citizenship and immigration status for each person who is applying for help.
- If you choose not give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying for AHCCCS Medical Assistance and/or help with Medicare costs.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for medical benefits. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a household member is in the U.S. illegally.

How long does it take to find out if I qualify for benefits after you receive my application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within **20 days if you are pregnant. If you need a disability determination report, we will make a decision within 90 days. For all other applicants, we will make a decision within 45 days.**

How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are American Indian and you choose American Indian Health Program as your health plan.
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How does a health plan work?

The health plan works with the health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services. The health plan will send you a member handbook once you are enrolled. You can call the health plan if you have any questions about your benefits or services or if you need interpreter services or an accommodation because of a disability. The telephone number for your health plan's member or customer service can be found on your AHCCCS ID card and in your Member Handbook.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

What is a primary doctor?

After you enroll in a health plan, your health plan will give you a list of primary doctors in your area to choose from. If you do not choose a primary doctor one will be assigned to you. You have the right to change your primary doctor at any time by calling your health plan's Member Services. Your primary doctor will:

- Take care of your health care
- Be the first person you go to for non-emergency medical services
- Send you to a specialist when needed

How do I get behavioral health services?

To get behavioral health services you can go through your primary doctor, or call the behavioral health telephone number on your AHCCCS ID card.

What if I have Medicare or other health insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS health plan, your doctor must call the AHCCCS health plan to coordinate care or you may be responsible for any Medicare or other health insurance co-payments or deductibles.
- If you are in an HMO, you should pick a primary doctor who works with both your HMO and your AHCCCS health plans.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (1-800-633-4227) or your AHCCCS health plan.

What is an AHCCCS ID card and what do I do with it?

Your AHCCCS ID card has your unique AHCCCS ID number.

- Show the card when you get medical care. You may also need to show picture ID.
- Doctors, hospitals and pharmacists use your AHCCCS ID card to obtain faster verification of eligibility.
- Keep your AHCCCS ID card with you at all times.
- Do not let anyone else use your AHCCCS ID card or you may be prosecuted.

What does AHCCCS Medical Assistance cost?

Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are $10 to $35 per person for employed people with disabilities.

Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- $2.30 to $10.00 for prescriptions
- $0.00 to $30.00 for non-emergency use of an emergency room
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctors office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

The following people are never asked to pay co-payments:

- Children under age 19.
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services.
- Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program.
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year.
- People who receive hospice care.

Co-payments are never charged for the following services for anyone:

- Hospitalizations
- Services paid for on a fee-for-service basis
- Emergency services
- Family planning services and supplies
- Pregnancy related health care including tobacco cessation for pregnant women

What are my rights and responsibilities?

You have the RIGHT to:

- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for AHCCCS Medical Assistance and/or help with Medicare costs and be given a letter that tells you if you are eligible or not.
- Review DES and/or AHCCCS manuals that show the rules and regulations of the DES and/or AHCCCS program if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or your DES and/or AHCCCS services being reduced, or if a decision is not made on your application within 45 days and the delay is due to DES or AHCCCS.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

You have the RESPONSIBILITY to:

- Provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility.
- Give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.
- Take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report changes timely.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS Health Plan.
- Before you choose a plan, check with your doctor, pharmacy or hospital, to see if they work with the plan that you want. If you want more information about the doctors, specialists or hospitals that work with a health plan that serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application. **This health plan choice does not affect your plan selection through the federal Health Insurance Marketplace.**

APACHE COUNTY
UnitedHealthcare Community Plan.....1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-729-8000

If your zip code is 85943, you must choose from the health plans listed under Navajo County.

COCHISE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 520-295-2479

COCONINO COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-283-2501

If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.

GILA COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care 1-800-582-8686
American Indian Health Program 928-475-2371

GRAHAM COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2686

If your zip code is 85643, you must choose from the health plans listed under Cochise County.

GREENLEE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2371

LA PAZ COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 928-669-2137

MARICOPA COUNTY
Health Net of Arizona 1-888-788-4408
Care 1st Arizona 1-866-560-4042
Health Choice Arizona 1-800-322-8670
UnitedHealthcare Community Plan 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
American Indian Health Program 602-263-1200

MOHAVE COUNTY
UnitedHealthcare Community Plan.....1-800-348-4058
Health Choice Arizona.....1-800-322-8670
American Indian Health Program.....928-769-2900

If your zip code is 86434, you must choose from the health plans listed under Yavapai County.

NAVAJO COUNTY
UnitedHealthcare Community Plan.....1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program.....928-338-4911

PIMA COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Care 1st Arizona.....1-866-560-4042
University Family Care.....1-800-582-8686
Mercy Care Plan.....1-800-624-3879
American Indian Health Program.....520-295-2479

If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.

PINAL COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care.....1-800-582-8686
American Indian Health Program.....520-562-3321

If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.

If your zip code is 85292 you must choose from the health plans listed under Gila County.

SANTA CRUZ COUNTY
University Family Care.....1-800-582-8686
UnitedHealthcare Community Plan.....1-800-348-4058
American Indian Health Service.....520-295-2479

YAVAPAI COUNTY
UnitedHealthcare Community Plan.....1-800-348-4058
University Family Care.....1-800-582-8686
American Indian Health Program.....602-263-1200

If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

If your zip code is 86351 you must choose from the health plans listed under Coconino County.

YUMA COUNTY
UnitedHealthcare Community Plan.....1-800-348-4058
University Family Care.....1-800-582-8686
American Indian Health Program.....760-572-4100

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

Application for Help with Health Coverage Costs

Contact Information:

Tell us how we can contact an adult member of your family.

Name (First, Middle, Last): _____

Home Address: _____ Apt. #_____ City: _____ State: ____ Zip Code: _____

Mailing Address (if different): _____ Apt. #_____ City: _____ State: ____ Zip Code: _____

Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the preferred SPOKEN household language? ❑ English ❑ Spanish ❑ Other: _____

What is the preferred WRITTEN household language? ❑ English ❑ Spanish ❑ Other: _____

I would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If "Yes" is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):

❑ Reading/understanding this application ❑ Filling out this application ❑ Other: _____

❑ American Sign Language ❑ Braille ❑ Language Interpreter Language: _____

I need the following accommodations for this application (check all that apply):

❑ Hearing ❑ Speaking ❑ Seeing ❑ Writing ❑ Walking ❑ Other: _____

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you. AHCCCS cannot release any information about your eligibility without your written consent.

Representative's Name: _____ Organization (if applicable): _____

Representative's Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Representative's Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Representative's Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the representative's preferred SPOKEN language? ❑ English ❑ Spanish ❑ Other: _____

What is the representative's preferred WRITTEN language? ❑ English ❑ Spanish ❑ Other: _____

My representative would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If "Yes" is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance and/or Medicare Savings Program. I, therefore:

- Give permission for my representative to complete and sign my application.
- Give permission for my representative to provide any documents requested, including personal information.
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
- Agree to give information about my personal circumstances to my representative.
- Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below I, the representative, agree to act on the customer's behalf. I also agree to:

- Provide only truthful and complete information under penalty of perjury.
- Fill in and sign needed forms.
- Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for AHCCCS Medical Assistance and/or Medicare Savings Program, such as the customer's Social Security number, income, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child).
- Tell DES and/or AHCCCS right away if the customer:
  - Has an increase or decrease in income;
  - Has a change in address; or
  - Has a change in health insurance.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Signature of Applicant: _____ Signature of Representative: _____

Date: _____ Date: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 1:

Tell us about each person in your family starting with you. See page A for a definition of who you must include. If you are a representative, tell us about the first person in the family applying.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Is PERSON 1 attending school full time? ❑ Yes ❑ No If yes, name of school: _____

Is PERSON 1 applying for help with health insurance costs? ❑ Yes ❑ No If yes, AHCCCS health plan choice: _____
OPTIONAL. See page D for enrollment plan choices.

Does PERSON 1 need help paying for medical bills from the last 3 months? ❑ Yes ❑ No If yes, what months? _____

Check here if PERSON 1 only wants help with Medicare costs? ❑ Medicare claim number: _____

If PERSON 1 is applying, continue answering the questions below.
If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.

Citizenship/Residency: Tell us about PERSON 1's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 1 a U.S. citizen or U.S. national? See page B for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 1 have? ❑ Permanent Resident card ❑ I-94 ❑ Visa ❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____ Has PERSON 1 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 1 an Arizona resident? ❑ Yes ❑ No

Did PERSON 1 move to Arizona in the last 4 months? ❑ Yes ❑ No
If yes, date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 1 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If yes, name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If no, is he/she eligible? ❑ Yes ❑ No

Program Screening: These questions will help determine what programs PERSON 1 may be eligible for.

If PERSON 1 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months? ❑ Yes ❑ No

If PERSON 1 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months? ❑ Yes ❑ No

Does PERSON 1 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility? ❑ Yes ❑ No

Is PERSON 1 pregnant? ❑ Yes ❑ No
If yes: Number of babies due: _____ Expected due date: _____

Does PERSON 1 live with at least one child under age 19 and is the main care taker of the child? ❑ Yes ❑ No

Has PERSON 1 ever received Supplemental Security Income (SSI Cash)? ❑ Yes ❑ No

Additional Questions:

Is PERSON 1 in jail or prison? ❑ Yes ❑ No

Was PERSON 1 released from jail or prison within the last 4 months? ❑ Yes ❑ No If yes, release date: _____

Go to the next page to tell us more about PERSON 1.

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PERSON 1:

Tell us about PERSON 1's expected taxes, income and potential benefits. Complete this page even if PERSON 1 is not applying.

Federal Income Tax Filing: Tell us how PERSON 1 will file income taxes NEXT YEAR.

Will PERSON 1 file taxes NEXT YEAR?	❑ Yes ❑ No	
If yes, will PERSON 1 file jointly with a spouse?	❑ Yes ❑ No	If yes, name of spouse: _____
Will PERSON 1 claim dependents on his/her tax return?	❑ Yes ❑ No	If yes, name of dependent(s): _____
Will PERSON 1 be claimed as a dependent on someone else's tax return?	❑ Yes ❑ No	If yes, name of tax filer: _____ Relationship to tax filer: _____
Does PERSON 1 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	❑ Alimony ❑ Student loan interest ❑ Other deductions	Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Describe deductions: _____

Employment: Tell us about PERSON 1's employment. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 1 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 1 self-employed?	❑ Yes ❑ No	If yes, type of work: _____ If yes, annual net amount: _____
Does PERSON 1's income change because of contract or seasonal employment?	❑ Yes ❑ No	If yes, how much income does PERSON 1 expect to make over the next 12 months? _____

Other Income: Tell us about other income PERSON 1 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 1 and his/her spouse to help determine if PERSON 1 may be eligible for additional benefits.

Has PERSON 1 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?	❑ Yes ❑ No	If yes, employer name: _____ If yes, dates of employment: _____
Is PERSON 1 or his/her spouse (living or deceased) a veteran?	❑ Yes ❑ No	If yes, branch of service: _____ If yes, dates of service: _____

Questions for People Under 19 Years Old: This section is only required if PERSON 1 is under age 19.

Is PERSON 1's parent (living or deceased) a veteran?	❑ Yes ❑ No	If yes, branch of service: _____ If yes, dates of service: _____
Does PERSON 1 have a parent living outside the home?	❑ Yes ❑ No	

Is there anyone else in PERSON 1's family? If **YES**, go to the next page to tell us about PERSON 2. If **NO**, go to page 12.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 2:

Tell us about the other people in your family. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Does PERSON 2 live at the same address as Person 1? ❑ Yes ❑ No
If no, what is PERSON 2's home address? _____

Is PERSON 2 attending school full time? ❑ Yes ❑ No If yes name of school: _____

Is PERSON 2 applying for help with health insurance costs? ❑ Yes ❑ No If yes, AHCCCS health plan choice: _____
OPTIONAL. See page D for enrollment plan choices.

Does PERSON 2 need help paying for medical bills from the last 3 months? ❑ Yes ❑ No If yes, what months? _____

Check here if PERSON 2 only wants help with Medicare costs? ❑ Medicare claim number: _____

If PERSON 2 is applying, continue answering the questions below.
If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.

Citizenship/Residency: Tell us about PERSON 2's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 2 a U.S. citizen or U.S. national? See page B for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 2 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 2 have? ❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____ Has PERSON 2 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 2 an Arizona resident? ❑ Yes ❑ No

Did PERSON 2 move to Arizona in the last 4 months? ❑ Yes ❑ No
If yes, date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 2 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If yes, name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If no, is he/she eligible? ❑ Yes ❑ No

Program Screening: These questions will help determine what programs PERSON 2 may be eligible for.

If PERSON 2 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months? ❑ Yes ❑ No

If PERSON 2 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months? ❑ Yes ❑ No

Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility? ❑ Yes ❑ No

Is PERSON 2 pregnant? ❑ Yes ❑ No
If yes: Number of babies due: _____ Expected due date: _____

Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child? ❑ Yes ❑ No

Has PERSON 2 ever received Supplemental Security Income (SSI Cash)?? ❑ Yes ❑ No

Additional Questions:

Is PERSON 2 in jail or prison? ❑ Yes ❑ No

Was PERSON 2 released from jail or prison within the last 4 months? ❑ Yes ❑ No If yes, release date: _____

Go to the next page to tell us more about PERSON 2.

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PERSON 2:

Tell us about PERSON 2's expected taxes, income and potential benefits. Complete this page even if PERSON 2 is not applying.

Federal Income Tax Filing: Tell us how PERSON 2 will file income taxes NEXT YEAR.

Will PERSON 2 file taxes NEXT YEAR?	❑ Yes ❑ No	
If yes, will PERSON 2 file jointly with a spouse?	❑ Yes ❑ No	If yes, name of spouse: _____
Will PERSON 2 claim dependents on his/her tax return?	❑ Yes ❑ No	If yes, name of dependent(s): _____
Will PERSON 2 be claimed as a dependent on someone else's tax return?	❑ Yes ❑ No	If yes, name of tax filer: _____ Relationship to tax filer: _____
Does PERSON 2 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	❑ Alimony ❑ Student loan interest ❑ Other deductions	Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Describe deductions: _____

Employment: Tell us about PERSON 2's employment. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 2 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 2 self-employed?	❑ Yes ❑ No	If yes, type of work: _____ If yes, annual net amount: _____
Does PERSON 2's income change because of contract or seasonal employment?	❑ Yes ❑ No	If yes, how much income does PERSON 2 expect to make over the next 12 months? _____

Other Income: Tell us about other income PERSON 2 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Other: _____			

Check here if this person does not have income ❑

Potential Benefits: Tell us about PERSON 2 and his/her spouse to help determine if PERSON 2 may be eligible for additional benefits.

Has PERSON 2 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?	❑ Yes ❑ No	If yes, employer name: _____ If yes, dates of employment: _____
Is PERSON 2 or his/her spouse (living or deceased) a veteran?	❑ Yes ❑ No	If yes, branch of service: _____ If yes, dates of service: _____

Questions for People Under 19 Years Old: This section is only required if PERSON 2 is under age 19.

Is PERSON 2's parent (living or deceased) a veteran?	❑ Yes ❑ No	If yes, branch of service: _____ If yes, dates of service: _____
Does PERSON 2 have a parent living outside the home?	❑ Yes ❑ No	

Is there anyone else in PERSON 1's family? If **YES**, go to the next page to tell us about PERSON 3. If **NO**, go to page 12.

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PERSON 3:

Tell us about the other people in your family. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Does PERSON 3 live at the same address as Person 1? ❑ Yes ❑ No
If no, what is PERSON 3's home address? _____

Is PERSON 3 attending school full time? ❑ Yes ❑ No If yes, name of school: _____

Is PERSON 3 applying for help with health insurance costs? ❑ Yes ❑ No If yes, AHCCCS health plan choice: _____
OPTIONAL. See page D for enrollment plan choices.

Does PERSON 3 need help paying for medical bills from the last 3 months? ❑ Yes ❑ No If yes, what months? _____

Check here if PERSON 3 only wants help with Medicare costs? ❑ Medicare claim number: _____

If PERSON 3 is applying, continue answering the questions below.
If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.

Citizenship/Residency: Tell us about PERSON 3's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 3 a U.S. citizen or U.S. national? See page B for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 3 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 3 have? ❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____ Has PERSON 3 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 3 an Arizona resident? ❑ Yes ❑ No

Did PERSON 3 move to Arizona in the last 4 months? ❑ Yes ❑ No
If yes, date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 3 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If yes, name of tribe: _____
Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If no, is he/she eligible? ❑ Yes ❑ No

Program Screening: These questions will help determine what programs PERSON 3 may be eligible for.

If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months? ❑ Yes ❑ No

If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months? ❑ Yes ❑ No

Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility? ❑ Yes ❑ No

Is PERSON 3 pregnant? ❑ Yes ❑ No
If yes: Number of babies due: _____ Expected due date: _____

Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child? ❑ Yes ❑ No

Has PERSON 3 ever received Supplemental Security Income (SSI Cash)? ❑ Yes ❑ No

Additional Questions:

Is PERSON 3 in jail or prison? ❑ Yes ❑ No

Was PERSON 3 released from jail or prison within the last 4 months? ❑ Yes ❑ No If yes, release date: _____

Go to the next page to tell us more about PERSON 3.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 3:

Tell us about PERSON 3's expected taxes, income and potential benefits. Complete this page even if PERSON 3 is not applying.

Federal Income Tax Filing: Tell us how PERSON 3 will file income taxes NEXT YEAR.

Will PERSON 3 file taxes NEXT YEAR?	❑ Yes	❑ No	
If yes, will PERSON 3 file jointly with a spouse?	❑ Yes	❑ No	If yes, name of spouse: _____
Will PERSON 3 claim dependents on his/her tax return?	❑ Yes	❑ No	If yes, name of dependent(s): _____
Will PERSON 3 be claimed as a dependent on someone else's tax return?	❑ Yes	❑ No	If yes, name of tax filer: _____ Relationship to tax filer: _____
Does PERSON 3 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	❑ Alimony ❑ Student loan interest ❑ Other deductions		Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Describe deductions: _____

Employment: Tell us about PERSON 3's employment. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 3 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 3 self-employed?	❑ Yes	❑ No	If yes, type of work: _____ If yes, annual net amount: _____
Does PERSON 3's income change because of contract or seasonal employment?	❑ Yes	❑ No	If yes, how much income does PERSON 3 expect to make over the next 12 months? _____

Other Income: Tell us about other income PERSON 3 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 3 and his/her spouse to help determine if PERSON 3 may be eligible for additional benefits.

Has PERSON 3 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?	❑ Yes	❑ No	If yes, employer name: _____ If yes, dates of employment: _____
Is PERSON 3 or his/her spouse (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____

Questions for People Under 19 Years Old: This section is only required if PERSON 3 is under age 19.

Is PERSON 3's parent (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____
Does PERSON 3 have a parent living outside the home?	❑ Yes	❑ No	

Is there anyone else in PERSON 1's family? If **YES**, go to the next page to tell us about PERSON 4. If **NO**, go to page 12.

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PERSON 4:

Tell us about the other people in your family. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Does PERSON 4 live at the same address as Person 1? ❑ Yes ❑ No
If no, what is PERSON 4's home address? _____

Is PERSON 4 attending school full time? ❑ Yes ❑ No If yes, name of school: _____

Is PERSON 4 applying for help with health insurance costs? ❑ Yes ❑ No If yes, AHCCCS health plan choice: _____
OPTIONAL. See page D for enrollment plan choices.

Does PERSON 4 need help paying for medical bills from the last 3 months? ❑ Yes ❑ No If yes, what months? _____

Check here if PERSON 4 only wants help with Medicare costs? ❑ Medicare claim number: _____

If PERSON 4 is applying, continue answering the questions below.

If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.

Citizenship/Residency: Tell us about PERSON 4's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 4 a U.S. citizen or U.S. national? See page B for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 4 have? ❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____ Has PERSON 4 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 4 an Arizona resident? ❑ Yes ❑ No

Did PERSON 4 move to Arizona in the last 4 months? ❑ Yes ❑ No
If yes, date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 4 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If yes, name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If no, is he/she eligible? ❑ Yes ❑ No

Program Screening: These questions will help determine what programs PERSON 4 may be eligible for.

If PERSON 4 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months? ❑ Yes ❑ No

If PERSON 4 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months? ❑ Yes ❑ No

Does PERSON 4 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility? ❑ Yes ❑ No

Is PERSON 4 pregnant? ❑ Yes ❑ No
If yes: Number of babies due: _____ Expected due date: _____

Does PERSON 4 live with at least one child under age 19 and is the main care taker of the child? ❑ Yes ❑ No

Has PERSON 4 ever received Supplemental Security Income (SSI Cash)? ❑ Yes ❑ No

Additional Questions:

Is PERSON 4 in jail or prison? ❑ Yes ❑ No

Was PERSON 4 released from jail or prison in the last 4 months? ❑ Yes ❑ No If yes, release date: _____

Go to the next page to tell us more about PERSON 4.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 4:

Tell us about PERSON 4's expected taxes, income and potential benefits. Complete this page even if PERSON 4 is not applying.

Federal Income Tax Filing: Tell us how PERSON 4 will file income taxes NEXT YEAR.

Will PERSON 4 file taxes NEXT YEAR?	❑ Yes	❑ No	
If yes, will PERSON 4 file jointly with a spouse?	❑ Yes	❑ No	If yes, name of spouse: _____
Will PERSON 4 claim dependents on his/her tax return?	❑ Yes	❑ No	If yes, name of dependent(s): _____
Will PERSON 4 be claimed as a dependent on someone else's tax return?	❑ Yes	❑ No	If yes, name of tax filer: _____ Relationship to tax filer: _____
Does PERSON 4 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	❑ Alimony ❑ Student loan interest ❑ Other deductions		Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Describe deductions: _____

Employment: Tell us about PERSON 4's employment. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 4 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 4 self-employed?	❑ Yes	❑ No	If yes, type of work: _____ If yes, annual net amount: _____
Does PERSON 4's income change because of contract or seasonal employment?	❑ Yes	❑ No	If yes, how much income does PERSON 4 expect to make over the next 12 months? _____

Other Income: Tell us about other income PERSON 4 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 4 and his/her spouse to help determine if PERSON 4 may be eligible for additional benefits.

Has PERSON 4 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?	❑ Yes	❑ No	If yes, employer name: _____ If yes, dates of employment: _____
Is PERSON 4 or his/her spouse (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____

Questions for People Under 19 Years Old: This section is only required if PERSON 4 is under age 19.

Is PERSON 4's parent (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____
Does PERSON 4 have a parent living outside the home?	❑ Yes	❑ No	

Is there anyone else in PERSON 1's family? If **YES**, go to the next page to tell us about PERSON 5. If **NO**, go to page 12.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 5:

If there are more than 5 people in your household, make a copy of pages 10 and 11, then tell us about the other people in your household. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Does PERSON 5 live at the same address as Person 1? ❑ Yes ❑ No
If no, what is PERSON 5's home address? _____

Is PERSON 5 attending school full time? ❑ Yes ❑ No If yes, name of school: _____

Is PERSON 5 applying for help with health insurance costs? ❑ Yes ❑ No If yes, AHCCCS health plan choice: _____
OPTIONAL. See page D for enrollment plan choices.

Does PERSON 5 need help paying for medical bills from the last 3 months? ❑ Yes ❑ No If yes, what months? _____

Check here if PERSON 5 only wants help with Medicare costs? ❑ Medicare claim number: _____

If PERSON 5 is applying, continue answering the questions below.
If NOT applying, skip this page and go to the next page to tell us about PERSON 1's income.

Citizenship/Residency: Tell us about PERSON 5's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 5 a U.S. citizen or U.S. national? See page B for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 5 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 5 have? ❑ Permanent Resident card ❑ I-94 ❑ Visa ❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____ Has PERSON 5 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 5 an Arizona resident? ❑ Yes ❑ No

Did PERSON 5 move to Arizona in the last 4 months? ❑ Yes ❑ No
If yes, date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 5 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If yes, name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If no, is he/she eligible? ❑ Yes ❑ No

Program Screening: These questions will help determine what programs PERSON 5 may be eligible for.

If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months? ❑ Yes ❑ No

If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months? ❑ Yes ❑ No

Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility? ❑ Yes ❑ No

Is PERSON 5 pregnant? ❑ Yes ❑ No
If yes: Number of babies due: _____ Expected due date: _____

Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child? ❑ Yes ❑ No

Has PERSON 5 ever received Supplemental Security Income (SSI Cash)? ❑ Yes ❑ No

Additional Questions:

Is PERSON 5 in jail or prison? ❑ Yes ❑ No

Was PERSON 5 released from jail or prison in the last 4 months? ❑ Yes ❑ No If yes, release date: _____

Go to the next page to tell us more about PERSON 5.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 5:

Tell us about PERSON 5's expected taxes, income and potential benefits. Complete this page even if PERSON 5 is not applying.

Federal Income Tax Filing: Tell us how PERSON 5 will file income taxes NEXT YEAR.

Will PERSON 5 file taxes NEXT YEAR?	❑ Yes	❑ No	
If yes, will PERSON 5 file jointly with a spouse?	❑ Yes	❑ No	If yes, name of spouse: _____
Will PERSON 5 claim dependents on his/her tax return?	❑ Yes	❑ No	If yes, name of dependent(s): _____
Will PERSON 5 be claimed as a dependent on someone else's tax return?	❑ Yes	❑ No	If yes, name of tax filer: _____ Relationship to tax filer: _____
Does PERSON 5 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.	❑ Alimony ❑ Student loan interest ❑ Other deductions Describe deductions:		Amount paid: _____ How often? _____ Amount paid: _____ How often? _____ Amount paid: _____ How often? _____

Employment: Tell us about PERSON 5's employment. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 5 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 5 self-employed?	❑ Yes	❑ No	If yes, type of work: _____ If yes, annual net amount: _____
Does PERSON 5's income change because of contract or seasonal employment?	❑ Yes	❑ No	If yes, how much income does PERSON 5 expect to make over the next 12 months? _____

Other Income: Tell us about other income PERSON 5 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Alimony			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 5 and his/her spouse to help determine if PERSON 5 may be eligible for additional benefits.

Has PERSON 5 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan?	❑ Yes	❑ No	If yes, employer name: _____ If yes, dates of employment: _____
Is PERSON 5 or his/her spouse (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____

Questions for People Under 19 Years Old: This section is only required if PERSON 5 is under age 19.

Is PERSON 5's parent (living or deceased) a veteran?	❑ Yes	❑ No	If yes, branch of service: _____ If yes, dates of service: _____
Does PERSON 5 have a parent living outside the home?	❑ Yes	❑ No	

Go to the next page to tell us about health insurance.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Health Insurance:

Answer the following questions for everyone applying.

Health Insurance Coverage:

Do any applicants have health insurance other than AHCCCS or Medicare? ❑ Yes ❑ No

If yes, give the following information:

If yes, give the following information:	Name of Insurance Provider:	Policy Number:	Coverage Effective Date:

Do any applicants have an injury or illness due to an accident or medical malpractice?	❑ Yes	❑ No	If yes, who? _____
Are any applicants currently admitted to a hospital?	❑ Yes	❑ No	If yes, who? _____

Health Insurance Tax Credits:

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

Insurance from Jobs: Tell us about health insurance that may be offered through a job.

Is anyone eligible for health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days? ❑ Yes ❑ No ❑ I do not know

If **YES**, answer the questions below. If **NO**, or **I DO NOT KNOW** go to the next page.

Tell us about the job that offers health insurance coverage. If there are plans offered by more than one employer and you need more space, please attach additional pages. If you need help with the information, contact the employer.

Employee Name: _____ Employee Social Security Number: _____

Employer Name: _____ Employer Identification Number (EIN): _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Who can we contact about employment health insurance coverage at this job? _____

If you are in a waiting or probationary period for insurance offered by an employer, when can you enroll in coverage? _____

Who is eligible for coverage from this job? _____

Does the employer offer a health plan that meets the minimum value standard*? ❑ Yes ❑ No ❑ I do not know

If **YES:** answer the questions below. If **NO** or **I DO NOT KNOW:** go to the next page.

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs:

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

What changes will the employer make for the new plan year (if known)?

❑ Employer will not offer health coverage

❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*.

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

❑ I do not know

Renewal of Tax Credit Coverage in Future Years:

To make it easier for the Federal Facilitated Marketplace to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make changes, and I can opt out at any time.

Yes, renew my eligibility for the next: ❑ 5 years ❑ 4 years ❑ 3 years ❑ 2 years ❑ 1 year

No, do not use information from tax returns to renew my coverage ❑

*An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Go to the next page to sign the application.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Sign the Application:

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- You must not knowingly withhold or give false information with the intent to receive or to continue receiving AHCCCS benefits to which you are not entitled.
- You will be required to pay back to AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my family are approved for AHCCCS benefits, AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that AHCCCS cannot collect more than the costs paid by AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

Statement of Truth

By signing this application:

- I agree I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Other Adult in Household: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Signature of Witness (if signed with mark): _____ Date: _____

Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. DES and AHCCCS cannot share any information about applicants without the applicant's written permission. This section is OPTIONAL.

Name of Hospital/Hospital's Agent/Organization/Agency: _____

Contact Person: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

I give permission for DES and/or AHCCCS staff to tell the hospital, hospital agent, organization, or agency listed above:

- That I have applied for AHCCCS Medical Assistance;
- The information or proof needed to see if I can get AHCCCS Medical Assistance; and
- If approved for AHCCCS Medical Assistance, the effective date of my eligibility, the redetermination due date, and the category of assistance for which I was approved. If denied for AHCCCS Medical Assistance, the reason I was denied.

Signature of Applicant: _____ Date: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Voter Registration:

Tell us if any person over the age of 18 listed on this application would like to register to vote. If yes, we will mail a voter registration form. You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote? ❑ Yes ❑ No ❑ Already registered to vote

If YES is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, AZ 85007
602-542-8683

Application Checklist:

Before submitting your application, remember to:

- ❑ Give us your contact information
- ❑ Include information about each person in your family
- ❑ Sign the application

Submit the Application:

Submit your completed and signed application along with any supporting documents to your local DES/FAA office.

If any additional information is needed, you will be contacted.
You will be notified of our decision.

Thank you for applying!

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Arizona Department of Economic Security/Family Assistance Administration (DES/FAA)
Arizona Health Care Cost Containment System (AHCCCS)

Application for Benefits

Tear off and keep pages A through H for your records.

What is this application for?

Use this application to see if you and members of your household qualify for:

- Free or low-cost insurance from AHCCCS
- Help with your Medicare costs
- Nutrition Assistance
- Cash Assistance/Temporary Assistance for Needy Families (TANF)
- Tuberculosis Control
- A new tax credit that can help pay your health insurance premiums

See page B for a description of each program.

Who can use this application?

An application may be completed by you or anyone you choose who knows or can get the information needed to complete the application for you and your household members. You can use this application to apply for anyone in your household, even if they already have benefits, including health insurance.

Your household includes:

- Your spouse, if married
- Your children under age 22 who live with you
- Your partner who lives with you (but only if you have a child together who needs health insurance or Cash Assistance)
- People you claim on your income tax return even if they do not live with you
- Relatives in your care who are under the age of 19 and live with you
- People who you live with that purchase and prepare food with you

If you want to select a representative to complete your application, complete the Authorized Representative form on page 1 of the application.

Where else can I apply?

You can apply faster online at www.healthearizonaplus.gov.

You can also apply in person at any local Department of Economic Security (DES)/Family Assistance Administration (FAA) office. You can find a list of local FAA offices at www.azdes.gov/faa, or can call our 24 hour Interactive Voice Response system at 1-855-HEA-PLUS (432-7587).

What information do I need to complete this application?

For everyone in your household, you may need:

- Birth dates
- Social Security numbers
- Employer and income information for everyone in your household
- Resources (e.g., bank account, cash, property)
- Expenses
- Information for any current health insurance
- Information about any job-related health insurance available to members of your household
- Other information needed to complete your application

Note: You can file an application with only your name, address, and the signature of a responsible household member or your authorized representative. This will hold your date of application but eligibility **cannot** be determined until you complete a full application and an interview, if needed.

Why do we ask for so much information?

We ask about income and other information to make sure you and members of your household get the correct benefits for your household.
We will keep all information you provide private, as required by law.

What happens next?

Send your completed, signed application to the address on page 21 or take it to your local DES office. If you do not have all of the information available, you can still submit your application and we will help you get the rest of the information.

What if I need help?

If you need help filling out this application, please tell us. If you need a language interpreter or accommodations for a disability, please check the kind of help you need on page 1 of the application.

Online: www.healthearizonaplus.gov
Phone: 1-855-HEA-PLUS (432-7587)
In person: Visit www.azdes.gov/faa to find the office closest to you.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Program Information:

You can use this application to apply for one or more programs. Each program has a symbol. On the application, look for the symbol for the program(s) you want to apply for and answer those questions. These are the symbols you will see on this application:

= Health Insurance Costs (AHCCCS Medical Assistance, Medicare Savings Program, Tax Credits)

= Nutrition Assistance

= Cash Assistance

= Tuberculosis Control

What is AHCCCS Medical Assistance?

AHCCCS stands for Arizona Health Care Cost Containment System, and it is the State of Arizona's Medicaid program. AHCCCS can provide medical benefits and help with Medicare costs to Arizona residents who meet certain income and other eligibility standards.

AHCCCS Medical Assistance covers the following medical services:

- Prescription Medication*
- Doctor's Office Visits**
- Laboratory and X-ray Services
- Hospital Services
- Dialysis
- Medical Supplies
- Medically Necessary Transportation
- Medically Necessary Specialist Care
- Behavioral Health Care
- Immunizations (shots)
- Chemotherapy
- Emergency Medical Care
- Rehabilitation Services
- 90 days of nursing care services

* AHCCCS prescription coverage is limited for people who have Medicare.
** Wellness visits for people age 21 and over are not covered.

What is Medicare Savings Program?

Medicare Savings Program may pay:

- Medicare Part A premium
- Medicare Part B premium
- Medicare deductibles and copayments
- Automatic Extra Help for Medicare Part D prescription expenses

What are Nutrition Assistance benefits?

Nutrition Assistance benefits help low-income families or individuals buy food for a healthier diet. If you have little or no money, you may be eligible for Emergency Nutrition Assistance benefits. Be sure to answer the Emergency Nutrition Assistance benefits questions on page 2 of this application.

What is Cash Assistance?

Cash Assistance gives temporary cash benefits to low income families. Parents or relatives of dependent children who are in their care may be eligible. Some families may qualify for a one-time lump sum cash assistance payment. We will determine if you qualify for this payment option.

What is Tuberculosis Control?

Tuberculosis Control gives cash support to individuals who are determined unable to work by the Department of Health Services as a result of communicable Tuberculosis.

What if I am not eligible for AHCCCS Medical Assistance?

If you are not eligible for AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

How does AHCCCS Medical Assistance work?

If you are approved for AHCCCS Medical Assistance, you will receive your health care from an AHCCCS health plan unless:

- You are American Indian and you choose American Indian Health Program as your health plan.
- You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Savings Programs (QMB), AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles.
- AHCCCS can only pay for your emergency services because of your status with United States Citizenship and Immigration Services (USCIS). If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

How much does AHCCCS Medical Assistance cost?

Premiums:

- Most people do not have to pay a monthly premium for AHCCCS Medical Assistance.
- Some people with income too high to qualify for AHCCCS Medical Assistance with no monthly premium may be able to get it by paying a monthly premium. If you have to pay a premium, the premium amounts are $10 to $35 per person for employed people with disabilities.

Co-payments:

A co-payment is the amount you pay a health care provider when you receive a medical service. Your co-payment amount will vary depending on which AHCCCS program you are enrolled in and the services you need. For some AHCCCS programs, the provider can deny services if the co-payments are not made. Co-payments for services are:

- $2.30 to $10.00 for prescriptions
- $0 to $30.00 for non-emergency use of an emergency room
- $3.40 to $5.00 for outpatient visits for evaluation and management services including doctor's office visits
- $2.30 to $3.00 for physical, occupational or speech therapy

Remember to report any changes in income because this may change your co-payment amount.

The following people are never asked to pay co-payments:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services (CRS) program
- People who are temporarily residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from co-payments is limited to 90 days in a contract year
- People who receive hospice care

Co-payments are never charged for the following services for anyone:

- Hospitalizations
- Services paid on a fee-for-service basis
- Emergency services
- Pregnancy related health care including tobacco cessation for pregnant women
- Family planning services

Do I need a Social Security number?

Federal law requires you give a Social Security number (SSN) for anyone who wants to get AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control (42 U.S.C. § 1320b-7; 42 U.S.C. § 405(c)(2)(C), 7 U.S.C. §§ 2011-2036, and Social Security Act (SSA) of 1935 (Section 1137) as amended by P.L. 98-369).

- If you or anyone you are applying for does not have a Social Security number, we will refer you to the Social Security office to apply for one. Immigrants who are not legally able to get a Social Security number are not required to give one or apply for one. Any person you are applying for who is legally able to get a Social Security number but does not have one or does not apply for one will not be eligible for benefits.
- If you are not applying for benefits for yourself, you do not have to give us your Social Security number. However, it may reduce the total amount of Nutrition Assistance and/or Cash Assistance benefits for the person you are applying for because we will not include you in the benefit amount.
- We will not use your SSN as your DES or AHCCCS identification number.
- We will not give any Social Security numbers to the United States Citizenship and Immigration Services (USCIS).

We use your information, including Social Security number, to:

- Verify identity
- Verity citizenship and immigration status
- Verify income and resources
- Prevent duplicate benefits
- Establish and enforce child support
- Computer match with state, local and federal agencies and our other programs to verify information
- Collect money we overpaid you in the form of benefits
- Share with other government agencies and their contractors to assess Nutrition Assistance and/or Cash Assistance program management and compliance
- We may give your information to law enforcement officials for the purpose of arresting persons fleeing to avoid the law

If we are not able to find proof of the information you have given us through the sources available to us, then you must provide proof of the information for us to decide if you are eligible.

DES and/or AHCCCS will keep your information for at least 7 years.

Do I have to give information about my citizenship and immigration status?

- To get the most help, you need to give us information about citizenship and immigration status for each person who is applying for help.
- Giving us the citizenship and immigration status for all people who are eligible for benefits allows us to include them in the Nutrition Assistance and/or Cash Assistance benefit amount. When you do not give us this information, it will not affect the eligibility of the people you are applying for who have given us verification of their citizenship or qualified non-citizen status, but it may affect the amount of the benefits for these people.
- If you choose not to give us information regarding immigration status but still want AHCCCS Medical Assistance, you may only be eligible for emergency medical services.
- You do not need to give us information about citizenship and immigration status for any person who is not applying.
- You do need to give us information on income, resources, or other information for those who have not given us citizenship or immigration status information to complete the application process.
- Under federal law, certain non-citizens such as refugees or political asylees may qualify for Medical Assistance, Nutrition Assistance, and/or Cash Assistance. For those non-citizens, United States Citizenship and Immigration Services (USCIS) guidelines state that use of these benefits will not affect your ability to become a Lawful Permanent Resident.
- If you are not applying for any benefits or if you chose not to provide citizenship or immigration information, we will not try to find out this information from USCIS.
- We will not report you, a family, or a household member to U.S. Immigration and Customs Enforcement (ICE) unless you inform us that you, your family or a household member is in the U.S. illegally.

Will I have to do an interview?

When applying for AHCCCS Medical Assistance and/or help with Medicare costs, an interview is not needed. When applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control you or your representative must complete an interview in person or by phone. If you need special accommodations for an interview, please tell us on page 1 of the application so we can be ready for your interview.

How long does it take to find out if I am eligible for benefits after you receive my application?

For AHCCCS Medical Assistance and/or help with Medicare costs, we will make a decision within **45** days.
- If you are pregnant, we will make a decision within **20** days.
- If you need a disability determination report, we will make a decision within **90** days.

For Nutrition Assistance, we will make a decision within **30** days.
- If you are eligible for Emergency Nutrition Assistance, we will make a decision within **7** days.

For Cash Assistance, we will make a decision within **45** days.
- If you are a relative or legal guardian applying only for children who are not your own, we will determine if the children qualify within **20** days.

How will I know if I am eligible?

- If you are approved for benefits, you will receive a letter explaining the benefits you are eligible for and the amount of benefits you will get.
- If you are denied, we will send you a letter explaining the reason for our decision.

How can I get my benefits when my application is approved?

If you are approved for AHCCCS Medical Assistance and/or help with Medicare costs, you will get an approval letter. You will get your AHCCCS ID card from your enrollment plan 10 to 14 business days after you get your approval letter. If you need medical services before you get your AHCCCS ID card, contact your enrollment plan.

If you are approved for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control:
- You will get an Electronic Benefit Transfer (EBT) card. This card works like a debit card. You will get a pamphlet with instructions on how to use your card.
- Your benefits are put on your EBT card after approval. It can take up to 48 hours for the benefits to be available. You can call the Customer Service number on the back of the card to check the balance of your benefits.
- If you are eligible for Emergency Nutrition Assistance, you may get an EBT card at your local DES/FAA office.
- If you qualify for Nutrition Assistance benefits, you can use the EBT card to buy approved food items. If you qualify for Cash Assistance benefits, you can use your EBT card to get cash or buy non-food items at any store where EBT cards are accepted. You may also withdraw your Cash Assistance benefits at ATMs, but there may be a fee.

What is expected of me?

For all programs:

- You must provide DES and/or AHCCCS with the needed information to correctly determine your eligibility and authorize DES and/or AHCCCS to investigate and contact any sources necessary to confirm the accuracy of the information for your eligibility.
- If you are approved for benefits, you will get a letter telling you what changes you must report. You MUST report your changes timely.

Program-specific expectations:

If applying for help with AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance, you must take necessary steps to obtain any annuities, pensions, retirement and disability benefits to which you may be entitled, including, but not limited to, Social Security benefits, Railroad retirement, Veterans benefits and unemployment compensation.

For AHCCCS Medical Assistance and/or Cash Assistance, you must give us any information you have about an absent parent. If you have reason for not providing this information (such as adoption pending, abuse, incest, neglect, etc.) you may claim good cause. You must cooperate with the Division of Child Support Services (DCSS) to establish paternity, unless you can prove good cause.

All adult household members and minor parents who are eligible for Nutrition Assistance and/or Cash Assistance benefits must be fingerprint imaged. Exceptions may apply.

What are my rights?

You have the RIGHT to:

- Courteous and professional treatment.
- Be treated fairly and equally regardless of race, color, religion, national origin, sex, age, disability, or political beliefs.
- Apply for benefits and be given a letter that tells you if you are eligible or not, and/or get a letter before your benefits are reduced or stopped.
- Review DES and AHCCCS policy manuals that show the rules and regulations of AHCCCS Medical Assistance, Medicare Savings Program, Nutrition Assistance, Cash Assistance, and Tuberculosis Control if you want to know the reason for our decision.
- Talk about your case with a worker or supervisor.
- Have all information you give regarding your eligibility kept private according to state and federal law.
- Ask for a fair hearing if you disagree with your application being denied, your benefits ended, or are being reduced, or if a decision is not made on your application within the allowable number of days and the delay is due to DES or AHCCCS.
- Look at your file before a fair hearing.
- Bring an attorney or any other person to a fair hearing.

To file a discrimination complaint, contact:

USDA, Director
Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, S.W.
Washington, D.C. 20250-9410

1-202-720-5964 (voice and TDD)

Attention: Regional Manager
U.S. Department of Health and Human Services
Office for Civil Rights/Region IX
50 United Nations Plaza, Room 322
San Francisco, CA 94102

1-800-368-1019 (voice)
1-415-437-8311 (TDD)

What are the Rules and Penalties?

If you, your representative, or any household member hides information or gives false information on purpose to get or continue to get Nutrition Assistance and/or Cash Assistance benefits that you are not entitled to, that person will be subject to:

- Criminal Prosecution
- Fines
- Imprisonment
- Other penalties provided for by state and federal laws

If you get Nutrition Assistance and/or Cash Assistance, you must follow the rules below:

- Do not make false statements or hide information. If you are not truthful, you may have to pay back DES for benefits you receive and you may be taken to court.
- Do not do anything dishonest to get benefits that you are not supposed to get.
- Do not buy, sell, trade, exchange or otherwise transfer your or someone else's Nutrition Assistance benefits or EBT card.
- Do not buy containers with deposits for the purpose of discarding the product and returning the containers to get cash refund deposits.
- Do not sell products bought with Nutrition Assistance benefits to exchange them for cash or items other than eligible food.
- Do not buy products originally bought with Nutrition Assistance benefits to exchange those products for cash or items other than eligible food.
- Do not steal Nutrition Assistance or Cash Assistance benefits.
- Do not use your Nutrition Assistance benefits to buy non-food items such as alcohol and tobacco.
- Do not alter an EBT card.
- Do not use someone else's EBT card unless you are an authorized user approved by DES.

If you knowingly break the rules and get Nutrition Assistance and/or Cash Assistance benefits, we will disqualify you from getting benefits for:

- 12 months for the first violation
- 24 months for the second violation
- Permanently for the third violation

You or a household member will not be eligible to get Nutrition Assistance and/or Cash Assistance benefits if you or the household member:

- Is a fleeing felon or probation/parole violator.
- Has been convicted of using or getting Nutrition Assistance benefits in a transaction involving the sale of firearms, ammunition or explosives. This person can never get Nutrition Assistance benefits again.
- Has been found guilty of using or getting Nutrition Assistance benefits in a transaction involving the sale of a controlled substance. This person is not eligible to get Nutrition Assistance benefits for 2 years for the first violation and permanently for the second violation.
- Has committed and was convicted of a federal or state felony on or after August 23, 1996 for the possession, use or distribution of a controlled substance.
- Has been found by a court of law to have given false identification or residence information in order to get benefits in more than one case. This person is not eligible to get benefits for 10 years.
- Refuses to sign and comply with the Personal Responsibility Agreement (PRA). We give you the PRA during the interview process.
- Is an adult recipient (18 years or older) of Cash Assistance when any of the following apply:
  - The recipient does not return the completed Illegal Drug Use Statement. We send the Illegal Drug Use Statement by U.S. Mail after Cash Assistance has been approved.
  - The recipient fails to take a required drug test.
  - The recipient fails the drug test.

You must pay DES back for any Nutrition Assistance and/or Cash Assistance benefits you received for which your household was not eligible. You can make a repayment agreement. If you do not keep your repayment agreement, we may reduce your Nutrition Assistance and/or Cash Assistance benefits, take your income tax refunds, or take other legal action, including taking the amounts from your earnings.

The following additional penalties apply to the Nutrition Assistance Program:

- An additional disqualification, of up to 18 months, may be ordered by a court.
- Any participant or household member who makes false statements or hides information can be fined up to $250,000.00, imprisoned for up to 20 years, or both.
- You and/or your household members may be subject to further prosecution under federal laws.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

How to Choose an AHCCCS Health Care Plan:

You need to choose a health plan that services your county.

- All AHCCCS health plans provide the same covered medical services.
- Review the health plans for your county listed below. American Indians may choose American Indian Health Program or an AHCCCS health plan.
- Before you choose a plan, check with your doctor, pharmacy, or hospital to see if they work with the plan that you want. If you want more information about the doctors, specialists, or hospitals that work with a health plan that serves your county, call the number listed below for the health plan.

If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

Enter the health plan choice on this application.

APACHE COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-729-8000

If your zip code is 85943, you must choose from the health plans listed under Navajo County.

COCHISE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 520-295-2479

COCONINO COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-283-2501

If your zip code is 86336 or 86340, you must choose from the health plans listed under Yavapai County.

GILA COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care 1-800-582-8686
American Indian Health Program 928-475-2371

GRAHAM COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2686

If your zip code is 85643, you must choose from the health plans listed under Cochise County.

GREENLEE COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Program 928-475-2371

LA PAZ COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 928-669-2137

MARICOPA COUNTY
Health Net of Arizona 1-888-788-4408
Care 1st Arizona 1-866-560-4042
Health Choice Arizona 1-800-322-8670
UnitedHealthcare Community Plan 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
American Indian Health Program 602-263-1200

MOHAVE COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-769-2900

If your zip code is 86434, you must choose from the health plans listed under Yavapai County.

NAVAJO COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
American Indian Health Program 928-338-4911

PIMA COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Care 1st Arizona 1-866-560-4042
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
American Indian Health Program 520-295-2479

If your zip code is 85645, you must choose from the health plans listed under Santa Cruz County.

PINAL COUNTY
Health Choice Arizona 1-800-322-8670
University Family Care 1-800-582-8686
American Indian Health Program 520-562-3321

If your zip code is 85242 or 85220, you must choose from the health plans listed under Maricopa County.

If your zip code is 85292 you must choose from the health plans listed under Gila County.

SANTA CRUZ COUNTY
University Family Care 1-800-582-8686
UnitedHealthcare Community Plan 1-800-348-4058
American Indian Health Service 520-295-2479

YAVAPAI COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 602-263-1200

If your zip code is 85342, 85358 or 85390, you must choose from the health plans listed under Maricopa County.

If your zip code is 86351 you must choose from the health plans listed under Coconino County.

YUMA COUNTY
UnitedHealthcare Community Plan 1-800-348-4058
University Family Care 1-800-582-8686
American Indian Health Program 760-572-4100

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

A)

Contact Information:

Tell us how we can contact an adult member of your household.

Name (First, Middle, Last): _____

Home Address: _____ Apt. #: ____ City: _____ State: ____ Zip Code: _____

Mailing Address (if different): _____ Apt. #: ____ City: _____ State: ____ Zip Code: _____

Do you live in a shelter? ❑ Yes ❑ No If 'Yes,' what kind of shelter? _____

Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the preferred SPOKEN household language? ❑ English ❑ Spanish ❑ Other: _____

What is the preferred WRITTEN household language? ❑ English ❑ Spanish ❑ Other: _____

I would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

I need the following help with this application (check all that apply):

❑ Reading/understanding this application ❑ Filling out this application ❑ Other: _____

❑ American Sign Language ❑ Braille ❑ Language Interpreter Language: _____

I need the following accommodations for this application (check all that apply):

❑ Hearing ❑ Speaking ❑ Seeing ❑ Writing ❑ Walking ❑ Other: _____

Authorized Representative:

This section is OPTIONAL. You may authorize someone else to represent you in the application process. DES and/or AHCCCS cannot release any information about your eligibility without your written consent.

Representative's Name: _____ Is representative your legal guardian? ❑ Yes ❑ No

Representative's Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Representative's Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Representative's Other Phone Number: _____ This number is: ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

What is the representative's preferred SPOKEN language? ❑English ❑ Spanish ❑ Other: _____

What is the representative's preferred WRITTEN language? ❑ English ❑ Spanish ❑ Other: _____

My representative would like to get information about this application by:

Email: ❑ Yes ❑ No Email address: _____

Text: ❑ Yes ❑ No Number to text (standard text rates apply): _____

If 'Yes' is not marked for Email or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.

By signing below I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:

- Give permission for my representative to complete and sign my application.
- Give permission for my representative to provide any documents requested, including personal information.
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.
- Agree to give information about my personal circumstances to my representative.
- Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below I, the representative, agree to act on the customer's behalf. I also agree to:

- Provide only truthful and complete information under penalty of perjury.
- Fill in and sign needed forms.
- Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as the customer's Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child).
- Tell DES and/or AHCCCS right away if the customer:
  - Has an increase or decrease in income;
  - Has an increase or decrease in assets;
  - Changes ownership of assets, including opening or closing financial accounts;
  - Has a change in address; or
  - Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Signature of Applicant: _____

Date: _____

Signature of Representative: _____

Date: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Release of Information to Hospitals/Hospital Agents/Organizations/Agencies:

You may give permission to DES and AHCCCS to release information about applicant eligibility. AHCCCS and DES cannot share any information about applicants without the applicant's written permission. This section is OPTIONAL.

Name of Hospital/Hospital's Agent/Organization/Agency: _____

Contact Person: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

I give permission for DES and/or AHCCCS staff to tell the hospital, hospital agent, organization, or agency listed above:

- That I have applied for AHCCCS Medical Assistance;
- The information or proof needed to see if I can get AHCCCS Medical Assistance ; and
- If approved for AHCCCS Medical Assistance, the effective date of my eligibility, the redetermination due date, and the category of assistance for which I was approved. If denied for AHCCCS Medical Assistance, the reason I was denied.

Signature of Applicant: _____ Date: _____

Access to Electronic Benefit Transfer (EBT) Account:

This section is OPTIONAL. If you are applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control You may choose a person, called an Alternate Cardholder, to get your benefits for you. If you need an Alternate Cardholder, choose a person you trust. Remember, lost or stolen benefits will not be replaced.

EBT Representative's Name: _____ EBT Representative's Date of Birth: _____

EBT Representative's Mailing Address: _____ City: _____ State: ___ Zip Code: _____

EBT Representative's Phone Number: _____ ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

EBT Representative's Other Phone Number: _____ ❑ Home ❑ Cell ❑ Work ❑ Message ❑ Other: _____

Signature of Applicant: _____ Date: _____

Someone Who Knows You Well:

We often need to contact people or organizations that can verify information to determine your eligibility for public assistance. When we contact these people or organizations we tell them your name, our title and that we work for the Department of Economic Security (DES). We are prohibited by law from telling them anything about you or about your assistance case. Please provide contact information below.

Name of someone who knows you well: _____ Relationship to you: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____

Name of Landlord: _____ Relationship to you: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____

Emergency Nutrition Assistance:

Is anyone in your household applying for Emergency Nutrition Assistance? If **YES**: fill out this section. If **NO**: go to page 3.

What is the total amount of income, before deductions, you expect to get this month?	$ _____
What is the total amount of cash on hand and money in your checking and savings account?	$ _____
What are the total monthly housing costs (rent or mortgage, taxes, homeowner/rental insurance, etc.)?	$ _____
What are the total monthly utility costs (gas, electric, phone, water, etc.) ?	$ _____
Does anyone receive Tribal Food Distribution?	❑ Yes ❑ No
Is anyone a migrant or seasonal farm worker?	❑ Yes ❑ No
Did anyone get Nutrition Assistance benefits from any other state? If 'Yes,' who received? _____ When? _____ State: _____	❑ Yes ❑ No

Go to the next page to tell us about PERSON 1.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 1:

Tell us about each person in your household, starting with you. See page A for a definition of who you must include. If you are a representative, tell us about the first person in the household applying.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Is PERSON 1 attending school? ❑ Yes ❑ No If 'Yes,' is PERSON 1 attending school : ❑ Full Time ❑ Part Time

Name of School: _____ Grade Level: _____

Is PERSON 1 applying for help with health insurance costs	❑ Yes	❑ No	If 'Yes,' AHCCCS health plan choice: _____ OPTIONAL. See page H for enrollment plan choices.
Is PERSON 1 applying for help with Medicare costs?	❑ Yes	❑ No	If 'Yes,' Medicare claim number: _____
Does PERSON 1 need help paying for medical bills from the last 3 months?	❑ Yes	❑ No	If 'Yes,' what months? _____
Is PERSON 1 applying for Nutrition Assistance?	❑ Yes	❑ No	
Is PERSON 1 applying for Cash Assistance?	❑ Yes	❑ No	
Is PERSON 1 applying for Tuberculosis Control?	❑ Yes	❑ No	

If PERSON 1 is applying for any benefits: continue answering the questions below.
If PERSON 1 is **NOT** applying for any benefits: go to page 5 to tell us about PERSON 1's income.

Citizenship/Residency:

Tell us about PERSON 1's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 1 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 1 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 1 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 1 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 1 an Arizona resident? ❑ Yes ❑ No

Did PERSON 1 move to Arizona in the last 4 months? ❑ Yes ❑ No
If 'Yes,' date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 1 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If 'Yes,' name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If 'No,' is he/she eligible? ❑ Yes ❑ No

Is he/she living on a reservation? ❑ Yes ❑ No If 'Yes,' name of reservation: _____

Tribal Census Number: _____

Go to the next page to tell us more about PERSON 1.

PERSON 1:

This section asks specific questions for each type of benefit. If PERSON 1 is not applying for any benefits, go to page 5. If PERSON 1 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 1 is applying for benefits.

Is PERSON 1 physically or mentally disabled?	❑ Yes ❑ No	
IS PERSON 1 in jail or prison?	❑ Yes ❑ No	
Was PERSON 1 released from jail or prison in the last 4 months?	❑ Yes ❑ No	If 'Yes,' release date: _____

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 1 is applying for help AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

Is PERSON 1 pregnant?	❑ Yes ❑ No	If 'Yes,' number of babies due: _____ If 'Yes,' expected due date: _____
If PERSON 1 is under age 19, are both of his/her parents living in the home? If 'No,' complete the information below:	❑ Yes ❑ No	

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 1 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

If PERSON 1 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	❑ Yes	❑ No
If PERSON 1 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	❑ Yes	❑ No
Does PERSON 1 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes	❑ No
Does PERSON 1 live with at least one child under age 19 and is the main care taker of the child?	❑ Yes	❑ No
Has PERSON 1 ever received Supplemental Security Income (SSI Cash)?	❑ Yes	❑ No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 1 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 1 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

Has PERSON 1 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes	❑ No	If 'Yes,' date of conviction: _____ City/state of conviction: _____ Type of conviction: _____
Has PERSON 1 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes	❑ No	If 'Yes,' name of state: _____
Is PERSON 1 fleeing from law enforcement agencies on any charges, or is PERSON 1 in violation of probation or parole according to a court?	❑ Yes	❑ No	

Nutrition Assistance Questions: Answer these questions if PERSON 1 is applying for Nutrition Assistance.

If PERSON 1 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	❑ Yes	❑ No
Is PERSON 1 living in an assisted living facility or group home?	❑ Yes	❑ No

Go to the next page to tell us more about PERSON 1.

PERSON 1:

Tell us about PERSON 1's income, potential benefits and expected tax filing status. Complete this page even if PERSON 1 is not applying for any benefits.

Employment: Tell us about PERSON 1's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 1 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 1 self-employed? ❑ Yes ❑ No If 'Yes,' type of work: _____
If 'Yes,' annual net (after deductions) amount: _____

If 'Yes,' has PERSON 1 been in this business for 12 months? ❑ Yes ❑ No If 'No,' date business started: _____

Does PERSON 1's income change because of contract or seasonal employment? ❑ Yes ❑ No If yes, how much income does PERSON 1 expect to make over the next 12 months? _____

Does PERSON 1 work in exchange for food or rent? ❑ Yes ❑ No If 'Yes,' where? _____

Other Income: Tell us about other income PERSON 1 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Supplemental Security Income (SSI Cash)			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Child support ❑ Court ordered ❑ Other: _____			
Alimony			
Veterans benefits			
Gifts or loans			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Check here if this person does not have income	❑		

Potential Benefits: Tell us about PERSON 1 to help determine if he/she may be eligible for additional benefits.

Has PERSON 1 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ❑ Yes ❑ No If 'Yes,' employer name: _____
If 'Yes,' dates of employment: _____

Has PERSON 1 or his/her spouse (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

If PERSON 1 is under age 19, has his/her parent (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

Federal Income Tax Filing: Tell us how PERSON 1 will file income taxes NEXT YEAR.

Will PERSON 1 file taxes NEXT YEAR? ❑ Yes ❑ No

If 'Yes,' will PERSON 1 file jointly with a spouse? ❑ Yes ❑ No If 'Yes,' name of spouse: _____

Will PERSON 1 claim dependents on his/her tax return? ❑ Yes ❑ No If 'Yes,' name of dependent(s): _____

Will PERSON 1 be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If 'Yes,' name of tax filer: _____
Relationship to tax filer: _____

Does PERSON 1 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.
❑ Alimony Amount paid: _____ How often? _____
❑ Student loan interest Amount paid: _____ How often? _____
❑ Other deductions Amount paid: _____ How often? _____
Describe deductions: _____

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 2. If **NO**, go to page 18.

PERSON 2:

Tell us about the other people in your household. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Does PERSON 2 live at the same address as Person 1? ❑ Yes ❑ No
If 'No,' what is PERSON 2's home address? _____

Is PERSON 2 attending school? ❑ Yes ❑ No If 'Yes,' is PERSON 2 attending school : ❑ Full Time ❑ Part Time
Name of school: _____ Grade Level: _____

✚ Is PERSON 2 applying for help with health insurance costs?	❑ Yes	❑ No	If 'Yes,' AHCCCS health plan choice: _____ OPTIONAL. See page H for enrollment plan choices.
✚ Is PERSON 2 applying for help with Medicare costs?	❑ Yes	❑ No	If 'Yes,' Medicare claim number: _____
✚ Does PERSON 2 need help paying for medical bills from the last 3 months?	❑ Yes	❑ No	If 'Yes,' what months? _____
● Is PERSON 2 applying for Nutrition Assistance?	❑ Yes	❑ No	
$ Is PERSON 2 applying for Cash Assistance?	❑ Yes	❑ No	
♿ Is PERSON 2 applying for Tuberculosis Control?	❑ Yes	❑ No	

If PERSON 2 is applying for any benefits: continue answering the questions below.
If PERSON 2 is **NOT** applying for any benefits: go to page 8 to tell us about PERSON 2's income.

✚ ● $ ♿ Citizenship/Residency: Tell us about PERSON 2's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 2 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 2 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)	❑ Battered Spouse, Child and Parent	❑ Removal/Suspension of Deportation
❑ Lawful Temporary Resident	❑ Cuban-Haitian Entrant	❑ Registry Applicants
❑ Non-Immigrant Status	❑ Deferred Action Status	❑ Special Immigrant Juvenile Status Applicant
❑ Asylee	❑ Deferred Enforced Departure	❑ Temporary Protection Status (TPS)
❑ Refugee	❑ Legalization under LIFE Act	❑ Victim of Trafficking
❑ Conditional Entrant Granted before 1980	❑ Legalization under IRCA Applicant	❑ Withholding of Deportation
❑ Other	❑ Order of Supervision	❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation
❑ I do not want to provide	❑ Paroled into United States	

What immigration document does PERSON 2 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 2 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 2 an Arizona resident? ❑ Yes ❑ No

Did PERSON 2 move to Arizona in the last 4 months? ❑ Yes ❑ No
If 'Yes,' date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If 'Yes,' name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If 'No,' is he/she eligible? ❑ Yes ❑ No

●$ Is he/she living on a reservation? ❑ Yes ❑ No If 'Yes,' name of reservation: _____

●$ Tribal Census Number: _____

Go to the next page to tell us more about PERSON 2.

PERSON 2:

This section asks specific questions for each type of benefit. If PERSON 2 is not applying for any benefits, go to page 8. If PERSON 2 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 2 is applying for benefits.

Is PERSON 2 physically or mentally disabled?	❑ Yes	❑ No	
IS PERSON 2 in jail or prison?	❑ Yes	❑ No	
Was PERSON 2 released from jail or prison in the last 4 months?	❑ Yes	❑ No	If 'Yes,' release date: _____

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 2 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

Is PERSON 2 pregnant?	❑ Yes	❑ No	If 'Yes,' number of babies due: _____ If 'Yes,' expected due date: _____
If PERSON 2 is under age 19, are both of his/her parents living in the home? If 'No,' complete the information below:	❑ Yes	❑ No	

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 2 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

If PERSON 2 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	❑ Yes	❑ No
If PERSON 2 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	❑ Yes	❑ No
Does PERSON 2 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes	❑ No
Does PERSON 2 live with at least one child under age 19 and is the main care taker of the child?	❑ Yes	❑ No
Has PERSON 2 ever received Supplemental Security Income (SSI Cash)?	❑ Yes	❑ No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 2 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 2 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

Has PERSON 2 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes	❑ No	If 'Yes,' date of conviction: _____ City/state of conviction: _____ Type of conviction: _____
Has PERSON 2 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes	❑ No	If 'Yes,' name of state: _____
Is PERSON 2 fleeing from law enforcement agencies on any charges, or is PERSON 2 in violation of probation or parole according to a court?	❑ Yes	❑ No	

Nutrition Assistance Questions: Answer these questions if PERSON 2 is applying for Nutrition Assistance.

If PERSON 2 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	❑ Yes	❑ No
Is PERSON 2 living in an assisted living facility or group home?	❑ Yes	❑ No

Cash Assistance Questions: Answer this question if PERSON 2 is under age 19 and applying for Cash Assistance.

If PERSON 2 is under age 19 and is living with his/her parents, are his/her shots current?	❑ Yes	❑ No

Go to the next page to tell us more about PERSON 2.

PERSON 2:

Tell us about PERSON 2's income, potential benefits and expected tax filing status. Complete this page even if PERSON 2 is not applying for any benefits.

Employment: Tell us about PERSON 2's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 2 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 2 self-employed? ❑ Yes ❑ No If 'Yes,' type of work: _____
If 'Yes,' annual net (after deductions) amount: _____

If 'Yes,' has PERSON 2 been in this business for 12 months? ❑ Yes ❑ No If 'No,' date business started: _____

Does PERSON 2's income change because of contract or seasonal employment? ❑ Yes ❑ No If yes, how much income does PERSON 2 expect to make over the next 12 months? _____

Does PERSON 2 work in exchange for food or rent? ❑ Yes ❑ No If 'Yes,' where? _____

Other Income: Tell us about other income PERSON 2 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Supplemental Security Income (SSI Cash)			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Child support ❑ Court ordered ❑ Other: _____			
Alimony			
Veterans benefits			
Gifts or loans			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 2 to help determine if he/she may be eligible for additional benefits.

Has PERSON 2 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ❑ Yes ❑ No If 'Yes,' employer name: _____
If 'Yes,' dates of employment: _____

Has PERSON 2 or his/her spouse (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

If PERSON 2 is under age 19, has his/her parent (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

Federal Income Tax Filing: Tell us how PERSON 2 will file income taxes NEXT YEAR.

Will PERSON 2 file taxes NEXT YEAR? ❑ Yes ❑ No

If 'Yes,' will PERSON 2 file jointly with a spouse? ❑ Yes ❑ No If 'Yes,' name of spouse: _____

Will PERSON 2 claim dependents on his/her tax return? ❑ Yes ❑ No If 'Yes,' name of dependent(s): _____

Will PERSON 2 be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If 'Yes,' name of tax filer: _____
Relationship to tax filer: _____

Does PERSON 2 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.
❑ Alimony Amount paid: _____ How often? _____
❑ Student loan interest Amount paid: _____ How often? _____
❑ Other deductions Amount paid: _____ How often? _____
Describe deductions: _____

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 3. If **NO**, go to page 18.

PERSON 3:

Tell us about the other people in your household. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Does PERSON 2 live at the same address as Person 1? ❑ Yes ❑ No
If 'No,' what is PERSON 2's home address? _____

Is PERSON 3 attending school? ❑ Yes ❑ No If 'Yes,' is PERSON 3 attending school : ❑ Full Time ❑ Part Time
Name of School: _____ Grade Level: _____

Is PERSON 3 applying for help with health insurance costs?	❑ Yes	❑ No	If 'Yes,' AHCCCS health plan choice: _____ OPTIONAL. See page H for enrollment plan choices.
Is PERSON 3 applying for help with Medicare costs?	❑ Yes	❑ No	If 'Yes,' Medicare claim number: _____
Does PERSON 3 need help paying for medical bills from the last 3 months?	❑ Yes	❑ No	If 'Yes,' what months? _____
Is PERSON 3 applying for Nutrition Assistance?	❑ Yes	❑ No	
Is PERSON 3 applying for Cash Assistance?	❑ Yes	❑ No	
Is PERSON 3 applying for Tuberculosis Control?	❑ Yes	❑ No	

If PERSON 3 is applying for any benefits: continue answering the questions below.
If PERSON 3 is **NOT** applying for any benefits: go to page 11 to tell us about PERSON 3's income.

Citizenship/Residency: Tell us about PERSON 3's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 3 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 3 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 3 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 3 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 3 an Arizona resident? ❑ Yes ❑ No

Did PERSON 3 move to Arizona in the last 4 months? ❑ Yes ❑ No
If 'Yes,' date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 3 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If 'Yes,' name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If 'No,' is he/she eligible? ❑ Yes ❑ No

Is he/she living on a reservation? ❑ Yes ❑ No If 'Yes,' name of reservation: _____

Tribal Census Number: _____

Go to the next page to tell us more about PERSON 3.

PERSON 3:

This section asks specific questions for each type of benefit. If PERSON 3 is not applying for any benefits, go to page 11. If PERSON 3 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 3 is applying for benefits.

Is PERSON 3 physically or mentally disabled?	❑ Yes	❑ No	
Is PERSON 3 in jail or prison?	❑ Yes	❑ No	
Was PERSON 3 released from jail or prison in the last 4 months?	❑ Yes	❑ No	If 'Yes,' release date: _____

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

Is PERSON 3 pregnant?	❑ Yes	❑ No	If 'Yes,' number of babies due: _____ If 'Yes,' expected due date: _____
If PERSON 3 is under age 19, are both of his/her parents living in the home? If 'No,' complete the information below:	❑ Yes	❑ No	

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 3 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

If PERSON 3 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	❑ Yes	❑ No
If PERSON 3 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	❑ Yes	❑ No
Does PERSON 3 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes	❑ No
Does PERSON 3 live with at least one child under age 19 and is the main care taker of the child?	❑ Yes	❑ No
Has PERSON 3 ever received Supplemental Security Income (SSI Cash)?	❑ Yes	❑ No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 3 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

Has PERSON 3 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes	❑ No	If 'Yes,' date of conviction: _____ City/state of conviction: _____ Type of conviction: _____
Has PERSON 3 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes	❑ No	If 'Yes,' name of state: _____
Is PERSON 3 fleeing from law enforcement agencies on any charges, or is PERSON 3 in violation of probation or parole according to a court?	❑ Yes	❑ No	

Nutrition Assistance Questions: Answer these questions if PERSON 3 is applying for Nutrition Assistance.

If PERSON 3 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	❑ Yes	❑ No
Is PERSON 3 living in an assisted living facility or group home?	❑ Yes	❑ No

Cash Assistance Questions: Answer this question if PERSON 3 is under age 19 and applying for Cash Assistance.

If PERSON 3 is under age 19 and is living with his/her parents, are his/her shots current?	❑ Yes	❑ No

Go to the next page to tell us more about PERSON 3.

PERSON 3:

Tell us about PERSON 3's income, potential benefits and expected tax filing status. Complete this page even if PERSON 3 is not applying for any benefits.

Employment: Tell us about PERSON 3's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 3 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 3 self-employed? ❑ Yes ❑ No If 'Yes,' type of work: _____
If 'Yes,' annual net (after deductions) amount: _____

If 'Yes,' has PERSON 3 been in this business for 12 months? ❑ Yes ❑ No If 'No,' date business started: _____

Does PERSON 3's income change because of contract or seasonal employment? ❑ Yes ❑ No If yes, how much income does PERSON 3 expect to make over the next 12 months? _____

Does PERSON 3 work in exchange for food or rent? ❑ Yes ❑ No If 'Yes,' where? _____

Other Income: Tell us about other income PERSON 3 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Supplemental Security Income (SSI Cash)			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Child support ❑ Court ordered ❑ Other: _____			
Alimony			
Veterans benefits			
Gifts or loans			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 3 to help determine if he/she may be eligible for additional benefits.

Has PERSON 3 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ❑ Yes ❑ No If 'Yes,' employer name: _____
If 'Yes,' dates of employment: _____

Has PERSON 3 or his/her spouse (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

If PERSON 3 is under age 19, has his/her parent (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

Federal Income Tax Filing: Tell us how PERSON 3 will file income taxes NEXT YEAR.

Will PERSON 3 file taxes NEXT YEAR? ❑ Yes ❑ No

If 'Yes,' will PERSON 3 file jointly with a spouse? ❑ Yes ❑ No If 'Yes,' name of spouse: _____

Will PERSON 3 claim dependents on his/her tax return? ❑ Yes ❑ No If 'Yes,' name of dependent(s): _____

Will PERSON 3 be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If 'Yes,' name of tax filer: _____
Relationship to tax filer: _____

Does PERSON 3 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.
❑ Alimony Amount paid: _____ How often? _____
❑ Student loan interest Amount paid: _____ How often? _____
❑ Other deductions Amount paid: _____ How often? _____
Describe deductions: _____

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 4. If **NO**, go to page 18.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

PERSON 4:

Tell us about the other people in your household. See page A for a definition of who you must include.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew Legal Guardian

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Does PERSON 2 live at the same address as Person 1? ❑ Yes ❑ No
If 'No,' what is PERSON 2's home address? _____

Is PERSON 4 attending school? ❑ Yes ❑ No If 'Yes,' is PERSON 4 attending school : ❑ Full Time ❑ Part Time
Name of School: _____ Grade Level: _____

Is PERSON 4 applying for help with health insurance costs?	❑ Yes	❑ No	If 'Yes,' AHCCCS health plan choice: _____ OPTIONAL. See page H for enrollment plan choices.
Is PERSON 4 applying for help with Medicare costs?	❑ Yes	❑ No	If 'Yes,' Medicare claim number: _____
Does PERSON 4 need help paying for medical bills from the last 3 months?	❑ Yes	❑ No	If 'Yes,' what months? _____
Is PERSON 4 applying for Nutrition Assistance?	❑ Yes	❑ No	
Is PERSON 4 applying for Cash Assistance?	❑ Yes	❑ No	
Is PERSON 4 applying for Tuberculosis Control?	❑ Yes	❑ No	

If PERSON 4 is applying for any benefits: continue answering the questions below.
If PERSON 4 is **NOT** applying for any benefits: go to page 14 to tell us about PERSON 4's income.

Citizenship/Residency: Tell us about PERSON 4's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 4 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 4 is NOT a U.S. citizen, what is his/her immigration status?

- ❑ Lawful Permanent Resident (LPR)
- ❑ Lawful Temporary Resident
- ❑ Non-Immigrant Status
- ❑ Asylee
- ❑ Refugee
- ❑ Conditional Entrant granted before 1980
- ❑ Other
- ❑ I do not want to provide
- ❑ Battered Spouse, Child or Parent
- ❑ Cuban-Haitian Entrant
- ❑ Deferred Action Status
- ❑ Deferred Enforced Departure
- ❑ Legalization under LIFE Act
- ❑ Legalization under IRCA Applicant
- ❑ Order of Supervision
- ❑ Paroled into United States
- ❑ Removal/Suspension of Deportation
- ❑ Registry Applicants
- ❑ Special Immigrant Juvenile Status Applicant
- ❑ Temporary Protection Status (TPS)
- ❑ Victim of Trafficking
- ❑ Withholding of Deportation
- ❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 4 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____

Immigration Document Number: _____
Has PERSON 4 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 4 an Arizona resident? ❑ Yes ❑ No

Did PERSON 4 move to Arizona in the last 4 months? ❑ Yes ❑ No
If 'Yes,' date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 4 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If 'Yes,' name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If 'No,' is he/she eligible? ❑ Yes ❑ No

Is he/she living on a reservation? ❑ Yes ❑ No If 'Yes,' name of reservation: _____

Tribal Census Number: _____

Go to the next page to tell us more about PERSON 4.

PERSON 4:

This section asks specific questions for each type of benefit. If PERSON 4 is not applying for any benefits, go to page 14. If PERSON 4 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 4 is applying for benefits.

Is PERSON 4 physically or mentally disabled?	❑ Yes	❑ No	
IS PERSON 4 in jail or prison?	❑ Yes	❑ No	
Was PERSON 4 released from jail or prison in the last 4 months?	❑ Yes	❑ No	If 'Yes,' release date: _____

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 4 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

Is PERSON 4 pregnant?	❑ Yes	❑ No	If 'Yes,' number of babies due: _____ If 'Yes,' expected due date: _____
If PERSON 4 is under age 19, are both of his/her parents living in the home? If 'No,' complete the information below:	❑ Yes	❑ No	

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 4 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

If PERSON 4 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	❑ Yes	❑ No
If PERSON 4 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	❑ Yes	❑ No
Does PERSON 4 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes	❑ No
Does PERSON 4 live with at least one child under age 19 and is the main care taker of the child?	❑ Yes	❑ No
Has PERSON 4 ever received Supplemental Security Income (SSI Cash)?	❑ Yes	❑ No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 4 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 4 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

Has PERSON 4 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes	❑ No	If 'Yes,' date of conviction: _____ City/state of conviction: _____ Type of conviction: _____
Has PERSON 4 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes	❑ No	If 'Yes,' name of state: _____
Is PERSON 4 fleeing from law enforcement agencies on any charges, or is PERSON 4 in violation of probation or parole according to a court?	❑ Yes	❑ No	

Nutrition Assistance Questions: Answer these questions if PERSON 4 is applying for Nutrition Assistance.

If PERSON 4 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	❑ Yes	❑ No
Is PERSON 4 living in an assisted living facility or group home?	❑ Yes	❑ No

Cash Assistance Questions: Answer this question if PERSON 4 is under age 19 and applying for Cash Assistance.

If PERSON 4 is under age 19 and is living with his/her parents, are his/her shots current?	❑ Yes	❑ No

Go to the next page to tell us more about PERSON 4.

PERSON 4:

Tell us about PERSON 4's income, potential benefits and expected tax filing status. Complete this page even if PERSON 4 is not applying for any benefits.

Employment: Tell us about PERSON 4's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 4 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 4 self-employed? ❑ Yes ❑ No If 'Yes,' type of work: _____
If 'Yes,' annual net (after deductions) amount: _____

If 'Yes,' has PERSON 4 been in this business for 12 months? ❑ Yes ❑ No If 'No,' date business started: _____

Does PERSON 4's income change because of contract or seasonal employment? ❑ Yes ❑ No If yes, how much income does PERSON 4 expect to make over the next 12 months? _____

Does PERSON 4 work in exchange for food or rent? ❑ Yes ❑ No If 'Yes,' where? _____

Other Income: Tell us about other income PERSON 4 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Supplemental Security Income (SSI Cash)			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Child support ❑ Court ordered ❑ Other: _____			
Alimony			
Veterans benefits			
Gifts or loans			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 4 to help determine if he/she may be eligible for additional benefits.

Has PERSON 4 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ❑ Yes ❑ No If 'Yes,' employer name: _____
If 'Yes,' dates of employment: _____

Has PERSON 4 or his/her spouse (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

If PERSON 4 is under age 19, has his/her parent (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

Federal Income Tax Filing: Tell us how PERSON 4 will file income taxes NEXT YEAR.

Will PERSON 4 file taxes NEXT YEAR? ❑ Yes ❑ No

If 'Yes,' will PERSON 4 file jointly with a spouse? ❑ Yes ❑ No If 'Yes,' name of spouse: _____

Will PERSON 4 claim dependents on his/her tax return? ❑ Yes ❑ No If 'Yes,' name of dependent(s): _____

Will PERSON 4 be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If 'Yes,' name of tax filer: _____
Relationship to tax filer: _____

Does PERSON 4 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.
❑ Alimony Amount paid: _____ How often? _____
❑ Student loan interest Amount paid: _____ How often? _____
❑ Other deductions Amount paid: _____ How often? _____
Describe deductions: _____

Is there anyone else in PERSON 1's household? If **YES**, go to the next page to tell us about PERSON 5. If **NO**, go to page 18.

PERSON 5:

If there are more than 5 people in your household, make a copy of pages 15, 16 and 17, then tell us about the other people in your household. See page A for a definition of who you must include. Attach copied pages to this application.

Personal Information:

Name (First, Middle, Last): _____ Gender: ❑ Male ❑ Female

Date of Birth: _____ Social Security Number (optional if not applying): _____

Relationship to Person 1: ❑ Spouse ❑ Child/Step Child ❑ Parent ❑ Other: _____
❑ Grandchild ❑ Niece/Nephew ❑ Legal Guardian

Marital Status: ❑ Never Married ❑ Divorced ❑ Widowed ❑ Married-name of spouse: _____

Does PERSON 2 live at the same address as Person 1? ❑ Yes ❑ No
If 'No,' what is PERSON 2's home address? _____

Is PERSON 5 attending school? ❑ Yes ❑ No If 'Yes,' is PERSON 5 attending school : ❑ Full Time ❑ Part Time
Name of School: _____ Grade Level: _____

✚ Is PERSON 5 applying for help with health insurance costs?	❑ Yes	❑ No	If 'Yes,' AHCCCS health plan choice: _____ OPTIONAL. See page H for enrollment plan choices.
✚ Is PERSON 5 applying for help with Medicare costs?	❑ Yes	❑ No	If 'Yes,' Medicare claim number: _____
✚ Does PERSON 5 need help paying for medical bills from the last 3 months?	❑ Yes	❑ No	If 'Yes,' what months? _____
● Is PERSON 5 applying for Nutrition Assistance?	❑ Yes	❑ No	
$ Is PERSON 5 applying for Cash Assistance?	❑ Yes	❑ No	
♿ Is PERSON 5 applying for Tuberculosis Control?	❑ Yes	❑ No	

If PERSON 5 is applying for any benefits: continue answering the questions below.
If PERSON 5 is **NOT** applying for any benefits: go to page 17 to tell us about PERSON 5's income.

Citizenship/Residency: Tell us about PERSON 5's citizenship/residency. You may need to provide proof of citizenship/residency.

Is PERSON 5 a U.S. citizen or U.S. national? See page D for more information. ❑ Yes ❑ No ❑ Choose not to answer

If PERSON 5 is NOT a U.S. citizen, what is his/her immigration status?

❑ Lawful Permanent Resident (LPR)
❑ Lawful Temporary Resident
❑ Non-Immigrant Status
❑ Asylee
❑ Refugee
❑ Conditional Entrant granted before 1980
❑ Other
❑ I do not want to provide
❑ Battered Spouse, Child or Parent
❑ Cuban-Haitian Entrant
❑ Deferred Action Status
❑ Deferred Enforced Departure
❑ Legalization under LIFE Act
❑ Legalization under IRCA Applicant
❑ Order of Supervision
❑ Paroled into United States
❑ Removal/Suspension of Deportation
❑ Registry Applicants
❑ Special Immigrant Juvenile Status Applicant
❑ Temporary Protection Status (TPS)
❑ Victim of Trafficking
❑ Withholding of Deportation
❑ Applicant for Asylum, LPR, TPS, or Withholding Deportation

What immigration document does PERSON 5 have?
❑ Permanent Resident card ❑ I-94 ❑ Visa
❑ Foreign Passport ❑ None ❑ Other: _____
Immigration Document Number: _____
Has PERSON 5 lived in the U.S. since August 22, 1996? ❑ Yes ❑ No

Is PERSON 5 an Arizona resident? ❑ Yes ❑ No
Did PERSON 5 move to Arizona in the last 4 months? ❑ Yes ❑ No
If 'Yes,' date moved: _____

Race (optional), select one or more:
❑ Asian ❑ Hawaiian or other Pacific Islander ❑ White
❑ Black or African American ❑ American Indian/Alaska Native ❑ Other: _____

Ethnicity (optional):
❑ Hispanic/Latino
❑ Non-Hispanic/Non-Latino

If PERSON 5 is American Indian or Alaska Native:
Is he/she enrolled in a federally recognized tribe? ❑ Yes ❑ No If 'Yes,' name of tribe: _____

Has he/she ever gotten services from Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No If 'No,' is he/she eligible? ❑ Yes ❑ No

●$ Is he/she living on a reservation? ❑ Yes ❑ No If 'Yes,' name of reservation: _____

●$ Tribal Census Number: _____

Go to the next page to tell us more about PERSON 5.

PERSON 5:

This section asks specific questions for each type of benefit. If PERSON 5 is not applying for any benefits, go to page 17. If PERSON 5 is applying for benefits, complete each applicable section.

Questions for All Applicants: Answer the following questions if PERSON 5 is applying for benefits.

Is PERSON 5 physically or mentally disabled?	❑ Yes	❑ No	
IS PERSON 5 in jail or prison?	❑ Yes	❑ No	
Was PERSON 5 released from jail or prison in the last 4 months?	❑ Yes	❑ No	If 'Yes,' release date: _____

AHCCCS Medical Assistance, Help with Medicare Costs, and Cash Assistance Questions:

Complete this section if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs, and/or Cash Assistance.

Is PERSON 5 pregnant? ❑ Yes ❑ No If 'Yes,' number of babies due: _____
If 'Yes,' expected due date: _____

If PERSON 5 is under age 19, are both of his/her parents living in the home? ❑ Yes ❑ No
If 'No,' complete the information below:

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

Parent's Name (First, Last): _____ Social Security Number: _____ Date of Birth: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Reason parent is absent: ❑ Deceased ❑ Out of home

AHCCCS Medical Assistance and Help with Medicare Costs Questions: Answer these questions if PERSON 5 is applying for AHCCCS Medical Assistance and/or help with Medicare costs.

If PERSON 5 is under the age of 65, does he/she have a mental or physical disability that has kept or will keep him/her from working for at least 12 months?	❑ Yes	❑ No
If PERSON 5 works and is under the age of 65, does he/she have a disability that is expected to last at least 12 months?	❑ Yes	❑ No
Does PERSON 5 need help with activities of daily living (bathing, dressing, etc.) through personal assistance, services, nursing home, or other medical facility?	❑ Yes	❑ No
Does PERSON 5 live with at least one child under age 19 and is the main care taker of the child?	❑ Yes	❑ No
Has PERSON 5 ever received Supplemental Security Income (SSI Cash)?	❑ Yes	❑ No

Nutrition Assistance and Cash Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance and/or Cash Assistance. PERSON 5 may still be able to get benefits if he/she has a felony drug conviction. See page G for more information.

Has PERSON 5 had a felony conviction for possession, use, or distribution of a controlled substance on or after August 23, 1996?	❑ Yes	❑ No	If 'Yes,' date of conviction: _____ City/state of conviction: _____ Type of conviction: _____
Has PERSON 5 been found to have committed a Nutrition Assistance and/or Cash Assistance Intentional Program Violation in Arizona or any other state?	❑ Yes	❑ No	If 'Yes,' name of state: _____
Is PERSON 5 fleeing from law enforcement agencies on any charges, or is PERSON 5 in violation of probation or parole according to a court?	❑ Yes	❑ No	

Nutrition Assistance Questions: Answer these questions if PERSON 5 is applying for Nutrition Assistance.

If PERSON 5 is disabled or over age 60, does he/she have any paid or unpaid medical expenses, even if he/she has medical insurance (example: travel expenses to and from medical provider, doctor visits, prescriptions, lab work, etc.)?	❑ Yes	❑ No
Is PERSON 5 living in an assisted living facility or group home?	❑ Yes	❑ No

Cash Assistance Questions: Answer this question if PERSON 5 is under age 19 and applying for Cash Assistance.

If PERSON 5 is under age 19 and is living with his/her parents, are his/her shots current?	❑ Yes	❑ No

Go to the next page to tell us more about PERSON 5.

PERSON 5:

Tell us about PERSON 5's income, potential benefits and expected tax filing status. Complete this page even if PERSON 5 is not applying for any benefits.

Employment: Tell us about PERSON 5's employment, including self-employment and rental income. You may need to provide proof of income. If self-employed, please attach the most current federal tax forms: 1040, SE, and applicable schedules such as C, C-EZ, E, F and K1. If you do not have tax forms, attach proof of business income and expenses for the last and current calendar month.

Does PERSON 5 work? ❑ Yes ❑ No If yes, give employment information below:

Employer's Name and Phone Number:	Gross Earnings (before deductions):	How often paid?	How many hours worked per week?

Is PERSON 5 self-employed? ❑ Yes ❑ No If 'Yes,' type of work: _____
If 'Yes,' annual net (after deductions) amount: _____

If 'Yes,' has PERSON 5 been in this business for 12 months? ❑ Yes ❑ No If 'No,' date business started: _____

Does PERSON 5's income change because of contract or seasonal employment? ❑ Yes ❑ No If yes, how much income does PERSON 5 expect to make over the next 12 months? _____

Does PERSON 5 work in exchange for food or rent? ❑ Yes ❑ No If 'Yes,' where? _____

Other Income: Tell us about other income PERSON 5 receives. You may need to provide proof of income.

Type of Income:	Amount:	How often received?	Who pays the income?
Social Security benefits			
Supplemental Security Income (SSI Cash)			
Retirement/pension			
Unemployment			
Disability/worker's compensation			
Child support ❑ Court ordered ❑ Other: _____			
Alimony			
Veterans benefits			
Gifts or loans			
Tribal money ❑ Gaming ❑ Other: _____			
Per capita payments from natural resources, usage rights, leases or royalties			
Payments from natural resources, farming, ranching, fishing, leases or royalties from Indian trust land			
Money from selling things that have cultural significance			
Other: _____			
Check here if this person does not have income ❑			

Potential Benefits: Tell us about PERSON 5 to help determine if he/she may be eligible for additional benefits.

Has PERSON 5 or his/her spouse (living or deceased) ever worked for a government agency or an employer with a pension plan? ❑ Yes ❑ No If 'Yes,' employer name: _____
If 'Yes,' dates of employment: _____

Has PERSON 5 or his/her spouse (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

If PERSON 5 is under age 19, has his/her parent (living or deceased) served in the military? ❑ Yes ❑ No If 'Yes,' branch of service: _____
If 'Yes,' dates of service: _____

Federal Income Tax Filing: Tell us how PERSON 5 will file income taxes NEXT YEAR.

Will PERSON 5 file taxes NEXT YEAR? ❑ Yes ❑ No

If 'Yes,' will PERSON 5 file jointly with a spouse? ❑ Yes ❑ No If 'Yes,' name of spouse: _____

Will PERSON 5 claim dependents on his/her tax return? ❑ Yes ❑ No If 'Yes,' name of dependent(s): _____

Will PERSON 5 be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If 'Yes,' name of tax filer: _____
Relationship to tax filer: _____

Does PERSON 5 pay any expenses that may be deducted on the federal income tax return? Do not include self-employment expenses. Check all that apply.
❑ Alimony Amount paid: _____ How often? _____
❑ Student loan interest Amount paid: _____ How often? _____
❑ Other deductions Amount paid: _____ How often? _____
Describe deductions: _____

Is there anyone else in PERSON 1's household? If **YES**, attach extra pages to tell us about the other people. If **NO**, go to page 18.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Nutrition Assistance, Cash Assistance and Tuberculosis Control Questions:

Is anyone in your household applying for Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control?
If **YES:** answer the questions below. If **NO:** go to the next page.

Temporary Absence: Tell us about any people who are temporarily living outside of your home that are expected to return.

Name (First and Last):	Date Left:	Expected Return Date:	Temporary Address:	Why are they out of the home?

Resources and Expenses: Answer the following questions if anyone in your household is applying for Nutrition Assistance and/or Cash Assistance.

Do you or anyone in your household own or have their name on bank accounts (checking or savings), credit union accounts, IRAs, Keoghs, or 401Ks?	❑ Yes ❑ No	If 'Yes,' total value: $ _____ Who owns? _____ Name of financial institution: _____
Do you or anyone in your household own or have their name on stocks, bonds, money market accounts, Certificates of Deposit (CD's), trust funds, or life insurance?	❑ Yes ❑ No	If 'Yes,' total value: $ _____ Who owns? _____ Name of financial institution: _____
Do you or anyone in your household own, rent, lease or maintain a home?	❑ Yes ❑ No	If 'Yes,' total value: _____ Who owns? _____ Where? _____
Do you or anyone in your household own real property (land or buildings)?	❑ Yes ❑ No	If 'Yes,' total value: $ _____ Who owns? _____ Where? _____
Do you or anyone in your household own vehicles (cars, trucks, boats, RVs, motorcycles, etc.)?	❑ Yes ❑ No	If 'Yes,' total value: $ _____ How many vehicles? _____
Do you or anyone in your household own other resources?	❑ Yes ❑ No	If 'Yes,' total value: $ _____ Describe resources: _____ Who owns? _____
Did you or anyone in your household ever apply for or get benefits from any other state?	❑ Yes ❑ No	If 'Yes,' who? _____ What type of benefits? _____ When did benefits stop? _____ Name of state/county: _____
Do you or anyone in your household pay for the care of a child or disabled adult in order to work, look for work, attend training, or attend school?	❑ Yes ❑ No	If 'Yes,' who pays? _____ Amount paid for care: $ _____ How often is care paid for? _____
Do you or anyone in your household have transportation costs to travel to/from the person or agency that provides provider, after school care or adult daycare?	❑ Yes ❑ No	If 'Yes,' amount: $ _____
Do you or anyone in your household pay court-ordered child support?	❑ Yes ❑ No	If 'Yes,' who pays? _____ Amount paid $ _____ How often paid? _____
Does your household have enough monthly income, cash and/or bank account balances to cover your monthly rent/mortgage, utility and child care payments?	❑ Yes ❑ No	If 'No,' how are you paying your bills? _____

Food Preparation: If anyone in your household is applying for Nutrition Assistance, tell us how your household buys and prepares food.

Does anyone in your household buy and prepare his/her own food separate from others in the household? ❑ Yes ❑ No

If 'Yes,' tell us about the people who buy and prepare their own food:

Name (First & Last):	Age:	Relationship to PERSON 1:	Does this person pay expenses?	What expenses?
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

Is anyone in your household applying for AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance?
If **YES**: Go to the next page. If **NO**: go to page 20.

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Health Insurance:

Health Insurance Coverage: Answer the following questions if anyone in your household is applying for AHCCCS Medical Assistance, help with Medicare costs, and/or Cash Assistance.

Do any applicants have health insurance other than AHCCCS or Medicare? ❑ Yes ❑ No

If 'Yes,' give the following information:

Name of Insured:	Name of Insurance Provider:	Policy Number:	Coverage Effective Date:

Answer the following questions for everyone applying for AHCCCS Medical Assistance and/or help with Medicare costs.

Do any applicants have an injury or illness due to an accident or medical malpractice? ❑ Yes ❑ No If 'Yes,' who? _____

Are any applicants currently admitted to a hospital? ❑ Yes ❑ No If 'Yes,' who? _____

Health Insurance Tax Credits:

If you are not eligible for you AHCCCS Medical Assistance, you may be eligible for federal tax credits to help with your health insurance premiums. If you are not eligible for any programs through AHCCCS, we will send your information to the federal Health Insurance Marketplace to see about health insurance tax credits.

Insurance from Jobs: Tell us about health insurance that may be offered through a job.

Is anyone eligible for health insurance coverage offered by an employer, or will you become eligible for coverage in the next 60 days? ❑ Yes ❑ No ❑ I do not know

If **YES:** answer the questions below. If **NO** or **I DO NOT KNOW:** go to the next page.

Tell us about the job that offers health insurance coverage. If there are plans offered by more than one employer and you need more space, please attach additional pages. If you need help with the information, contact the employer.

Employee Name: _____ Employee Social Security Number: _____

Employer Name: _____ Employer Identification Number (EIN): _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Who can we contact about employment health insurance coverage at this job? _____

If you are in a waiting or probationary period for insurance offered by an employer, when can you enroll in coverage? _____

Who is eligible for coverage from this job? _____

Does the employer offer a health plan that meets the minimum value standard*? ❑ Yes ❑ No ❑ I do not know

If **YES:** answer the questions below. If **NO** or **I DO NOT KNOW:** go to the next page.

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs:

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Twice a month ❑ Every 2 Weeks ❑ Monthly ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

What changes will the employer make for the new plan year (if known)?

❑ Employer will not offer health coverage

❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*.

How much will the employee have to pay in premiums for that plan? $ _____ ❑ I do not know

How often will the employee have to pay the premium?

❑ Weekly ❑ Twice a month ❑ Every 2 Weeks ❑ Monthly ❑ Quarterly ❑ Yearly ❑ I do not know ❑ Other: _____

❑ I do not know

Renewal of Tax Credit Coverage in Future Years:

To make it easier for the Federal Facilitated Marketplace to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make changes, and I can opt out at any time.

Yes, renew my eligibility for the next: ❑ 5 years ❑ 4 years ❑ 3 years ❑ 2 years ❑ 1 year

No, do not use information from tax returns to renew my coverage ❑

*An employer-sponsored health plan meets "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Go to the next page to sign the application.

Sign the Application:

The application is not valid until it is signed. All unrelated adults without a child in common must sign the application. Otherwise, the application must be signed by one of the following:

- The applicant or the applicant's designee (we must have documentation showing this person is authorized to act on the applicant's behalf); or
- The applicant's spouse, if married and living within the same household; or
- The parent/legal guardian of a minor child.

Penalty Warning

The information provided on this form may be verified by federal, state, and local officials. If any information is inaccurate, you may be denied benefits.

- You must not knowingly withhold or give false information with the intent to receive or to continue receiving DES and/or AHCCCS benefits to which you are not entitled.
- You will be required to pay back to DES and/or AHCCCS any benefits you receive as a result of withholding or giving false information and you will be subject to criminal prosecution.
- It is fraud for any person to knowingly withhold information with the intent to receive or continue to receive benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, criminal prosecution, imprisonment or other penalties as provided for by applicable State and Federal laws.

Release of Information

I authorize DES and/or AHCCCS to investigate and contact any sources necessary to establish eligibility and the accuracy of financial information that pertains to AHCCCS eligibility.

Assignment of Rights to Other Benefits for Medical Care

I understand that if I am or members of my household are approved for DES and/or AHCCCS benefits, DES and/or AHCCCS can collect payment from any other parties who may be responsible for paying for my/our health costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that DES and/or AHCCCS cannot collect more than the costs paid by DES and/or AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

I understand that DES and/or AHCCCS and/or their contractors will release information to DES/Division of Child Support Services (DCSS), for a parent of a child who does not live in the home and the child has AHCCCS or private health insurance. DCSS may use this information to get a medical support order.

Assignment of Rights to Other Benefits for Cash Assistance

State and federal law (A.R.S. 46-407) provide that the legal rights to child support and spousal maintenance must be assigned to the State of Arizona for all persons receiving Cash Assistance. I understand:

- While receiving Cash Assistance, the State has the right to keep child support or spousal maintenance collections, including support or spousal maintenance that was owed while Cash Assistance was paid.
- When Cash Assistance stops, current support payments will be paid to me. The state may continue to collect any assigned back payments for support (assigned arrears) owed before and during the time I received Cash Assistance.
- Child support payments will be used to pay back the state for Cash Assistance paid to me or anyone on my application.
- The State will not keep more from my collected current support or assigned arrears than the total amount of Cash Assistance I received.
- Also the State will not keep any arrears that are more than the total amount of Cash Assistance I received.

Statement of Truth

By signing this application:

- I agree I have read and understand the rules and penalties on page G. I have read and understand my rights and responsibilities, and provided Social Security numbers for each applicant that has a Social Security number.
- I agree I have read and understand the assignment or rights to other benefits for Medical Care above.
- I agree I have read and understand the assignment of support rights for Cash Assistance above.
- I agree that certain Nutrition Assistance and/or Cash Assistance household members will cooperate with the work programs, which includes looking for work and accepting training and/or a job. If anyone does not, or will not, look for work, attend training, or accept a job, my benefits may be reduced or stopped.
- I agree to cooperate with Arizona or Federal personnel in the completion of a quality control review on my eligibility for benefits.
- In the event DES or its agents engage in child support enforcement activities involving me, I understand the Assistant Attorneys General and Deputy County Attorneys handling the cases represent DES, and not me or my children.
- If my child support case goes to court, I understand certain personal information contained in this application or my DES records may be released to the court and other parties to the case and becomes a public record document.
- I also hereby agree to accept service of process by first class mail with regard to any paternity or child support proceeding initiated by DES and its agents.
- I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law.

I swear under penalty of perjury that the statements and documents provided about myself and persons in my home, that relates to my eligibility for benefits, is true and correct to the best of my knowledge, and that I have not withheld any information. I swear under penalty of perjury that any photocopied information I have provided are the same as the original documents.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Signature of Other Adult in Household: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Signature of Witness (if signed with mark): _____ Date: _____

Do you need help with this application? Visit www.healthearizonaplus.gov or call 1-855-HEA-PLUS (432-7587)

Voter Registration:

Tell us if any person over the age of 18 listed on this application would like to register to vote. If 'Yes,' we will mail a voter registration form.

You may also access a voter registration form at www.azsos.gov/election/voterinformation.htm. If you would like help filling out the voter registration application form, we will help you. You may fill out the application form in private. Your answer to this question will not impact the programs you are eligible for.

Would any person on this application over the age of 18 like to register to vote? ❑ Yes ❑ No ❑ Already registered to vote

If **YES** is not checked, all persons over the age of 18 on this application will be considered to have decided not to register to vote at this time.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, AZ 85007
602-542-8683

Submit the Application:

Submit your completed and signed application along with any supporting documents to your local DES/FAA office.

If any additional information is needed, you will be contacted.
You will be notified of our decision.

Thank you for applying!

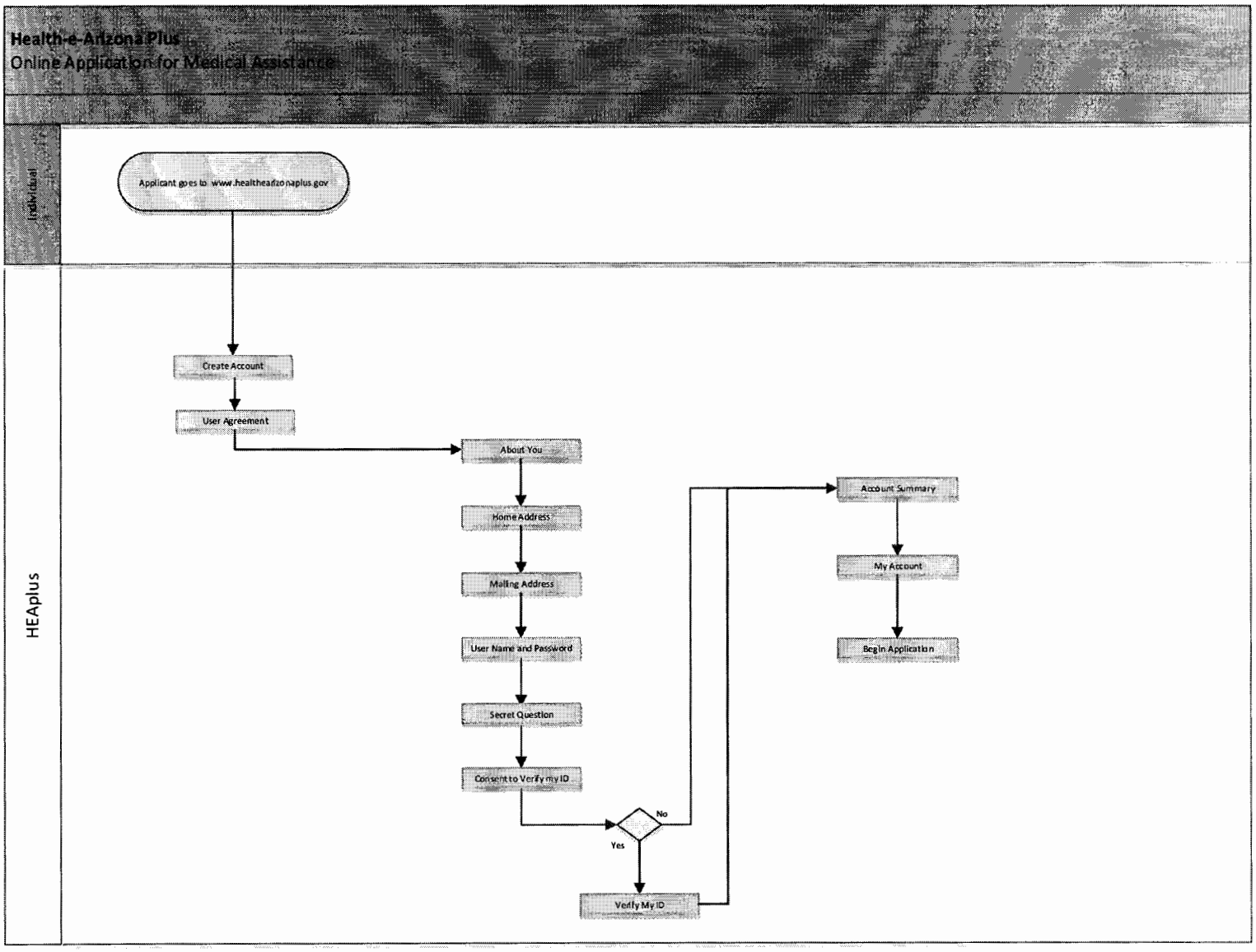
Health-e-Arizona Online Application Roadmap for Medical Assistance

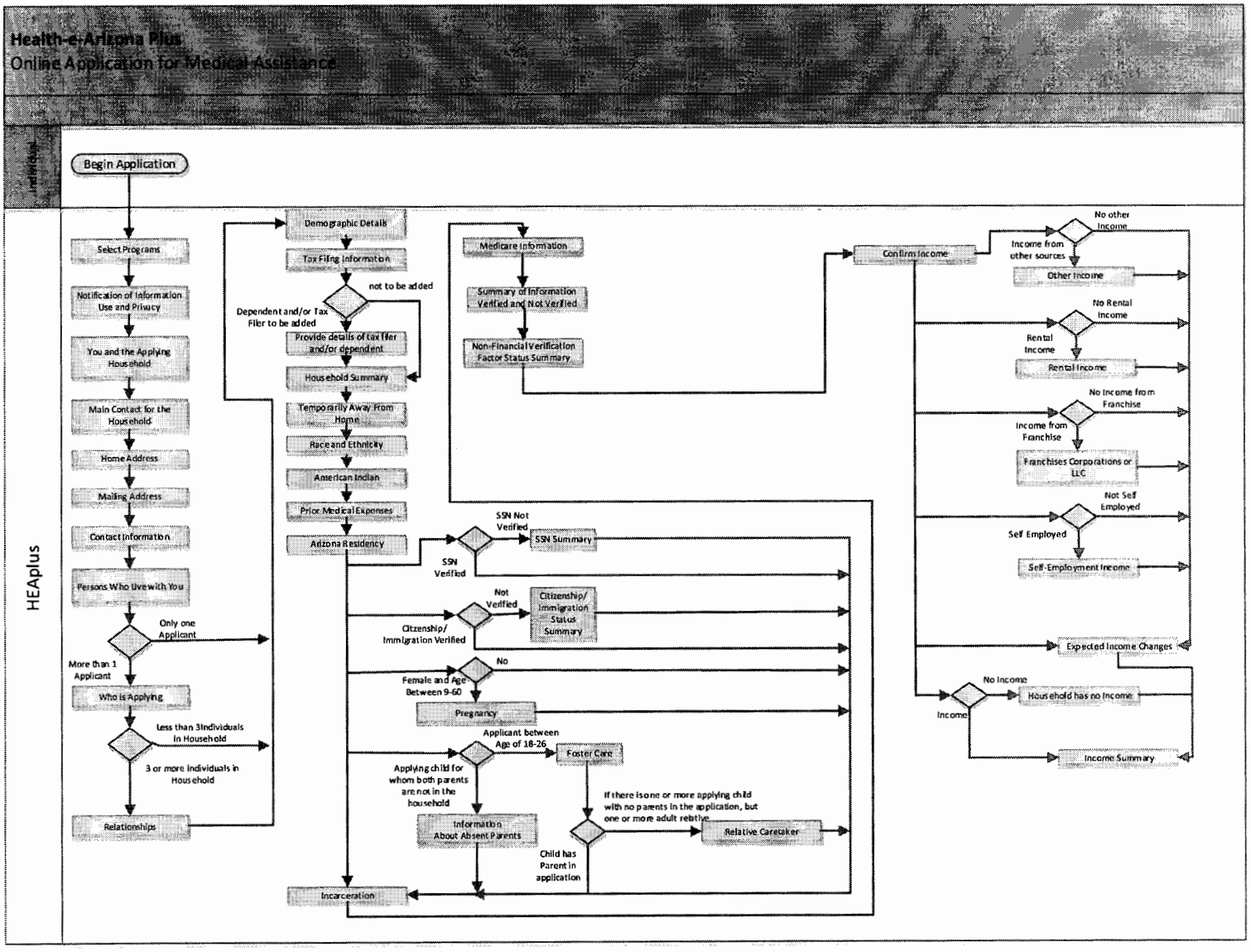
Note: Arizona's CHIP Program is Currently Frozen

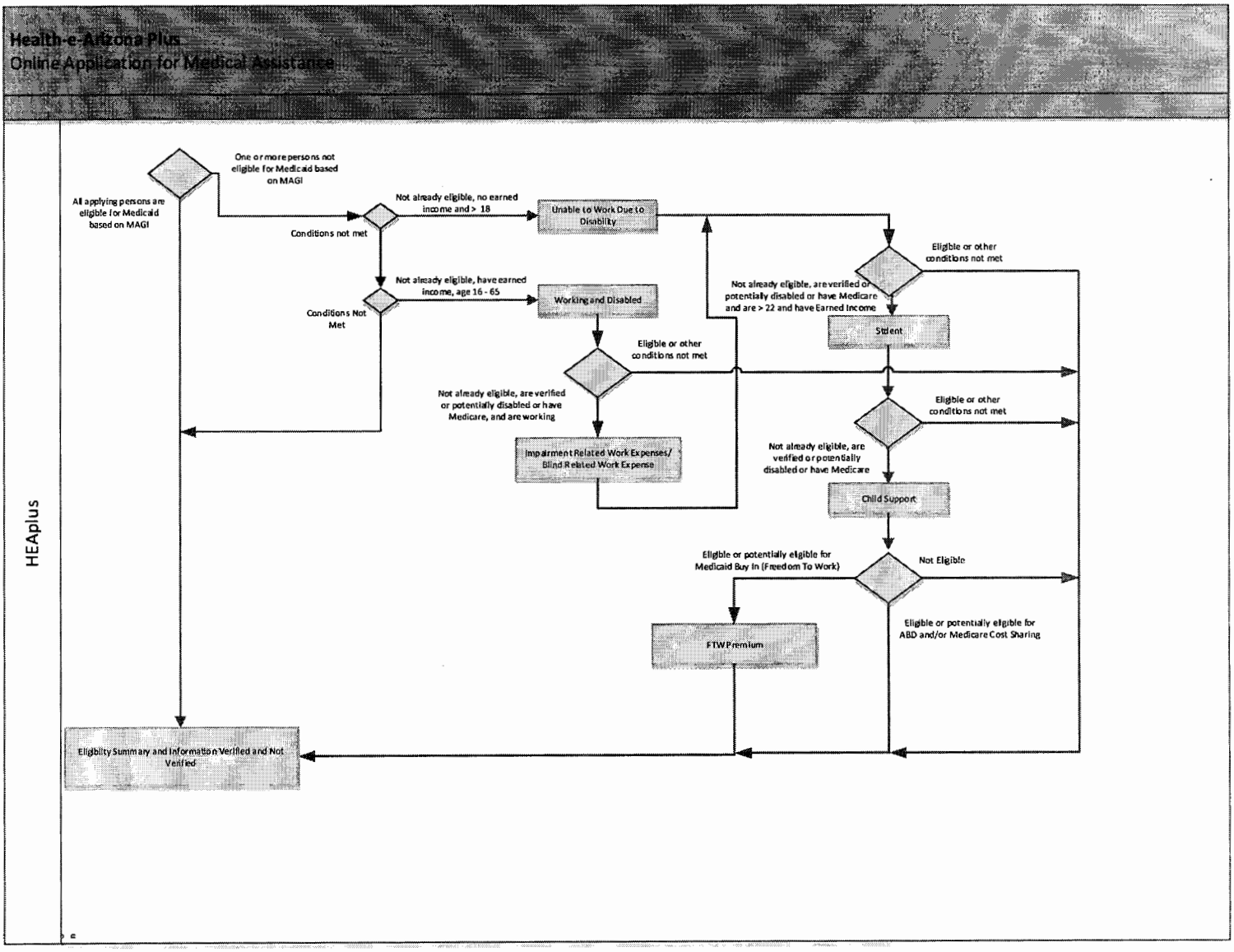
Persons Applying/Not Applying	Online Application Page	Page Condition	Additional Comment
	Account Creation - User Agreement		
	Account Creation - About You		Identifying information, email, phone numbers and communicaiton preferences
	Home Address		
	Mailing Address		
	User Name and Password		
	Secret Questions		
	Consent to Verify Identity		
	Identity Verification		
	Account Summary		
	Select Programs		
	Notification of Information Use and Privacy		
	You and the Applying Household		Questions to establish whether the customer is applying for him/herself or his/her family or houesehold or is a representative for another household
	Main Contact Information		Identifying information about the primary applicant or representative
	Contact Home Address		
	Contact Mailing Address		
	Other Contact Information		Email and phone numbers
	Persons Who Live With You		Establishes who the applicant intends to include
All Persons	Who is Applying?	This screen will display if there is more than one person listed on the application	Establishes which persons want benefits
All Persons	Relationships	This screen will display only when there are three or more individuals in the household to define relationships between other applicants.	
All Persons	Demographic Details		Captures DOB, SSN (optional if not applying
Applying Persons	Demographic Details		Captures DOB, SSN, Citizenship, Immigration Status and related information.
Primary Applicant	Tax Household Information		Collects the primary applicant's tax filing plans, status, and any dependents, including dependents living out of the household or whether he/she is a tax dependent (if appropriate)
All Other Persons	Tax Household Information	This screen will display for persons 18 or older to capture other tax filers in the home	Collects all other persons' tax filing plans, status, and any dependents, including dependents living out of the household or whether each is a tax dependent (if appropriate)
All Other Persons	Additional Tax Household Information	This screen will display for any tax dependent of a filer that he/she does not live with	Provides the option to supply information about the tax filer, which is necessary for eligibility for APTC
All Persons	Household Summary		
Applying Persons	Temporarily Away From Home		
All Persons	Race and Ethnicity		
All Persons	American Indian		
Applying Persons	Prior Medical Expenses (Prior Quarter Coverage)		To be implemented for January 2014
Applying Persons	Arizona Residency		
	SSN Verification Results	This screen will display when one or more persons in the household has a SSN that could not be verified	Allows correction of entries and retry of verification or collection of clarifying information
	Citizenship/Immigration Summary	This screen will display when one or more persons in the household has Citizenship/Immigration Status that could not be verified	Collects clarifying information

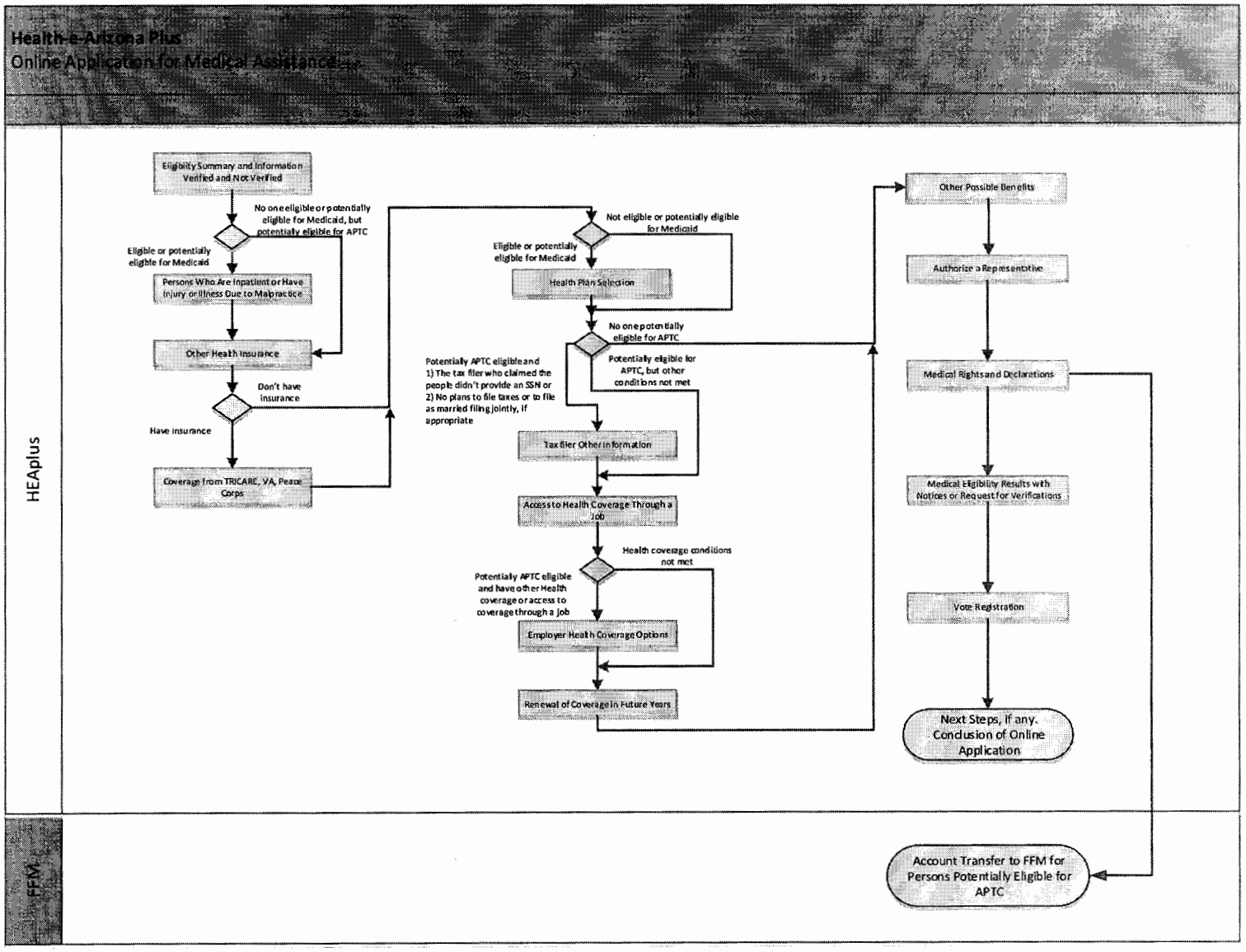
Applying Females (Medical) in the pregnancy range	Pregnancy	This screen will display if there is one or more female applicants between ages 9-60	
	Tell Us About Parents (Absent Parent(s))	This screen will display for if there is one or more applying children for whom one or both parents are not in the household	
	Caretaker Relative	This screen will display if there is one or more children with no parents in the application, but one or more adult relative	
Applying Persons	Incarceration		
Applying Persons	Medicare Coverage		
All Persons	Summary of Information Verified and Not Verified		Display of summary as feedback and transition
All Persons	Confirm Income Found From Electronic Sources		
All Persons	Additional Income Information		Collects incidence of income for jobs not found be electronic sources, self employment and other income and determines what additional pages are needed to collect income
All Persons	Rental Income	This screen will display for persons indicated to have Rental Income on the Additional Income Information screen	
All Persons	Self-Employment Income	This screen will display for persons indicated to have self-employment income on the Additional Income Information screen	
All Persons	Income from Franchises, Corporations or LLC	This screen will display for persons indicated to have income from Franchise, Corporation or LLC on the Additional Income Information screen	
All Persons	Other Income	This screen should only display for persons who selected that they have Other Income on the Income Information screen	
All Persons	Expected Income Changes		Collects reasonably predictable changes
All Persons	Household Has No Income	This screen will display if the the household that attests to having no income	
All Persons	Income Summary		
All Persons apart of the Tax Household	Allowed Deductions From Income	This screen will display if any applying person is not eligible for Medical Assistance at this point. If everyone in the household is eligible for Medical Assistance at this point, the system will skip this screen.	
	At this point, the system will know if the applicant(s) are eligible for Medicaid based on MAGI. The system may know whether persons are eligible for ABD, Medicaid Buy In or Medicare Cost Sharing (QMB, SLMB, QI-1) For persons that are not yet found eligible, the system will present pages and questions, as appropriate to determine the potential for eligibility in ABD, Medicaid Buy In or Medicare Cost Sharing. **Note:** Arizona's CHIP program is currently frozen)		
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Unable to Work Due to Disability	This screen will only display for persons who were not already eligible, DO NOT have EARNED income, and are greater than 18 years of age and are not already known to be disabled based on data from electronic sources	Eligibility checked if potential linkage to ABD exists
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Working and Disabled	This screen will only display for persons who were not already eligible, have EARNED income, are between the ages of 16-65 and are not already known to be disabled based on data from electronic sources	Eligibility checked if potential linkage to Medicaid Buy In (called Freedom to Work) exists

Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Impairment Related Work Expenses/Blind Related Work Expenses	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare, and are working	Eligibility checked with deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Student	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare and are > 22 and have Earned Income	Eligibility checked with appropriate deductions applied
Applying Persons Not Already Found Eligible for Medicaid based on MAGI	Child Support	This screen will only display for persons who were not already eligible, are verified or potentially disabled or have Medicare	Eligibility for ABD checked with deductions applied
Person(s) eligible or potentially eligible for Medicaid Buy In (Program Called Freedom to Work)	Freedom to Work Premium	This sreen will display for persons who are eligible or potentially eligible for Freedom To Work.	
All Persons	Eligibiity Summary and Information Verified and Not Verified		Display of summary as feedback and transition
	Post Eligibility Questions Required to Complete Application		
Persons Eligible or Potentially Eligible for Medicaid	Persons Who Are Inpatient or Have Injury or Illness Due to Malpractice	This sreen will display if there are persons eligible or potentially eligible for Medicaid pending verification.	Question regarding inpatient is required by State Rule to indicate need for expedited processing. It is not necessary if eligibility is successfully completed real-time. Question regarding potential source of TPL applies to any person eligible or potentially eligible for Medicaid
Persons Eligible or Potentially Eligible for Medicaid	Other Health Insurance		
All Persons Eligible or Potentially Eligible for Medicaid or APTC	Insurance Coverage through TRICARE, VA, Peace Corps	This screen should only display for persons who selected that they have insurance on the Insurance Information screen (previous screen)	
Persons Eligible or Potentially Eligible for Medicaid	Health Plan Selection	This screen will display if applicants are potentially eligible for a Medicaid program	This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice.
Applying Persons Potentially Eligible for APTC	Tax Filer Other Information	This screen will display for persons who are potentially APTC eligible and 1) The tax filer who claimed the people didn't provide an SSN 2) People who are potentially eligible for APTC but did not plan to file a tax return or were not indicated as dependents 3) People who are potentially eligible for APTC and ARE married but indicated that they do not plan to file as married filing a joint return.	
Applying Persons Potentially Eligible for APTC	Insurance Coverage through a Job	This screen will display if there is one or more persons potentially APTC eligible	
Applying Persons Potentially Eligible for APTC who entered Other Health Coverage Information on the previous screen	Employer Health Coverage Options	This screen will display for persons who are potentially APTC eligible and who entered Other Health Coverage Information (on the previous screen)	
Applying Persons Potentially Eligible for APTC	Renewal of Coverage in Future Years	This screen will display if there is one or more persons potentially eligible for APTC	
Persons Eligible or Potentially Eligible for Medicaid	Other Possible Benefits		Potential for access to pension or veterans administration benefits
	Name an Authorized Representative		
	Rights and Declarations - Signature		
	Eligibility Results with Notices and/or Request for Verification		
	Vote Registration		
	Next Steps		Next Steps as applicable to complete the eligibility and enrollment process or access benefits


Health-e-Arizona Plus
Online Application for Medical Assistance
Individual
HEAplus
Applicant goes to www.healthearizonaplus.gov
Create Account
User Agreement
About You
Home Address
Mailing Address
User Name and Password
Secret Question
Consent to Verify my ID
No
Yes
Verify My ID
Account Summary
My Account
Begin Application


Health-e-Arizona Plus
Online Application for Medical Assistance
Individual
HEAplus
Begin Application
Select Programs
Notification of Information Use and Privacy
You and the Applying Household
Main Contact for the Household
Home Address
Mailing Address
Contact Information
Persons Who Live with You
Only one Applicant
More than 1 Applicant
Who is Applying
Less than 3Individuals in Household
3 or more Individuals in Household
Relationships
Demographic Details
Tax Filing Information
not to be added
Dependent and/or Tax Filer to be added
Provide details of tax filer and/or dependent
Household Summary
Temporarily Away From Home
Race and Ethnicity
American Indian
Prior Medical Expenses
Arizona Residency
Medicare Information
Summary of Information Verified and Not Verified
Non-Financial Verification Factor Status Summary
SSN Not Verified
SSN Summary
SSN Verified
Not Verified
Citizenship/ Immigration Status Summary
Citizenship/ Immigration Verified
No
Female and Age Between 9-60
Pregnancy
Applicant between Age of 18-26
Foster Care
Applying child for whom both parents are not in the household
Information About Absent Parents
If there is one or more applying child with no parents in the application, but one or more adult relative
Relative Caretaker
Child has Parent in application
Incarceration
Confirm Income
No other Income
Income from other sources
Other Income
No Rental Income
Rental Income
Rental Income
No Income from Franchise
Income from Franchise
Franchises Corporations or LLC
Not Self Employed
Self Employed
Self-Employment Income
Expected Income Changes
No Income
Household has no Income
Income
Income Summary


Health-e-Arizona Plus
Online Application for Medical Assistance
HEAplus
All applying persons are eligible for Medicaid based on MAGI
One or more persons not eligible for Medicaid based on MAGI
Conditions not met
Not already eligible, no earned income and > 18
Unable to Work Due to Disability
Conditions Not Met
Not already eligible, have earned income, age 16 - 65
Working and Disabled
Not already eligible, are verified or potentially disabled or have Medicare, and are working
Eligible or other conditions not met
Impairment Related Work Expenses/ Blind Related Work Expense
Not already eligible, are verified or potentially disabled or have Medicare and are > 22 and have Earned Income
Eligible or other conditions not met
Student
Not already eligible, are verified or potentially disabled or have Medicare
Eligible or other conditions not met
Child Support
Eligible or potentially eligible for Medicaid Buy In (Freedom To Work)
Not Eligible
FTW Premium
Eligible or potentially eligible for ABD and/or Medicare Cost Sharing
Eligibility Summary and Information Verified and Not Verified


Health-e-Arizona Plus
Online Application for Medical Assistance
HEAplus
FFM
Eligibility Summary and Information Verified and Not Verified
No one eligible or potentially eligible for Medicaid, but potentially eligible for APTC
Eligible or potentially eligible for Medicaid
Persons Who Are Inpatient or Have Injury or Illness Due to Malpractice
Other Health Insurance
Don't have insurance
Have Insurance
Coverage from TRICARE, VA, Peace Corps
Not eligible or potentially eligible for Medicaid
Eligible or potentially eligible for Medicaid
Health Plan Selection
No one potentially eligible for APTC
Potentially APTC eligible and 1) The tax filer who claimed the people didn't provide an SSN or 2) No plans to file taxes or to file as married filing jointly, if appropriate
Potentially eligible for APTC, but other conditions not met
Tax filer Other Information
Access to Health Coverage Through a Job
Health coverage conditions not met
Potentially APTC eligible and have other Health coverage or access to coverage through a job
Employer Health Coverage Options
Renewal of Coverage in Future Years
Other Possible Benefits
Authorize a Representative
Medical Rights and Declarations
Medical Eligibility Results with Notices or Request for Verifications
Vote Registration
Next Steps, if any. Conclusion of Online Application
Account Transfer to FFM for Persons Potentially Eligible for APTC

Key Differences Between Arizona's Health-e-Arizona Plus Online Application and the CMS Document for the Health Insurance Marketplace Online Application

Health-e-Arizona Plus (www.healthearizonaplus.gov) will be Arizona's integrated online application for Medicaid, CHIP, SNAP, and TANF Cash Assistance.

The Health-e-Arizona Plus online application was compared to the CMS document ***List of Items in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program***, 4/29/2013.

The following questions or data elements are collected on the CMS Health Insurance Marketplace online application, but are not on the Health-e-Arizona Plus online application:

Eligible Immigration Status

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

Potential Disability

Per the CMS document, disability related questions are asked of all applicants to 'screen applicants for the potential for Medicaid eligibility on a basis other than Modified Adjusted Gross Income (MAGI)'. Arizona asks potential disability questions only for those persons not otherwise confirmed to be disabled by electronic data sources and who are not already found eligible on the basis of MAGI.

Expedited Income

Per the CMS document, Section IX, describes a process 'for tax filers whose income tax data indicates that the household income is above a certain amount so the household doesn't need to answer questions about current/monthly income.' Arizona will not use FTI and does not ask these questions.

American Indian/Alaska Native income questions

While income, including tribal income is collected, it is collected along with all other types of income, rather than broken out to a separate series of questions.

Discrepancies

The CMS document includes 10 questions asked for an person where the electronic income data is not reasonably compatible with the household income attestation. Arizona asks similar conditional questions when, upon reviewing the income data from electronic sources, indicates that the income data is not, or no longer, accurate. These questions and the rules associated with the answers to these questions are integral to Arizona's verification plan and specifically Arizona's rules for reasonable compatibility.

Special Enrollment Periods

We have not included special enrollment period questions for potential APTC eligible persons. The CMS paper Single Streamlined Application does not include these questions. Guidance also indicates that these are not required for alternative paper or online applications.

The following questions or data elements are collected on the Health-e-Arizona Plus online application, but are not on the CMS Health Insurance Marketplace online application:

Questions Related to All Medical Assistance Programs

Relationships

We ask for relationships of all persons in relation to other persons, not just in relationship to the primary applicant.

Immigration Status

Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use Because there is a requirement that a Medicaid applicant attest to their qualified immigration status, we cannot use the method outlined on the CMS single streamlined application. Not all legal statuses are Medicaid qualified immigration statuses. Therefore, we have listed the statuses for selection. We also provide the individual with the option to indicate they do not want to provide their immigration status. In this situation the person can only be eligible for emergency services.

Pregnancy

We ask for the expected due date in order to follow-up when no newborn has been reported by the expected due date.

Arizona resident

We ask this question to ensure that the individual considers him/herself a resident of Arizona. We also ask whether any applying person has moved to Arizona in the last month (or in the last four months if prior quarter coverage is needed).

Potential Benefits

We ask two questions to identify potential benefits for which the individual may be eligible. This includes through access to pension or veterans administration benefits

No Income

For households attesting to having 'No Income', we ask questions related how they are meeting their needs. Based on the answers to the questions, they may have income that is considered countable income (e.g., working odd jobs) that they had not previously entered. As indicated in our verification plan, we will perform post eligibility checks of data sources at 6 months to determine if the household is receiving income.

Questions Related to Medicaid and CHIP only

Inpatient
State rule requires that we determine eligibility expedited timeframe for persons who are inpatient in a hospital inpatient. This question is asked following eligibility determination, but before signature.

Injury or illness due to an accident or medical malpractice

We ask this question to identify potential sources of third party liability. This question is asked following eligibility determination, but before signature and is a federal requirement to pursue sources of third party liability

Health Plan Choice

We ask the individuals who are eligible for Medicaid or CHIP, or are eligible pending verification, to indicate their health plan choice. This is an optional question, but is important to the completion of their enrollment and avoid additional contact to obtain their choice. This question is asked following eligibility determination, but before signature.

Questions Related to CHIP Only (Note: Arizona's CHIP program enrollment is frozen)

Chronic or Serious Illness

If the CHIP program should reopen, we would ask if any CHIP eligible child, that has lost insurance in the last 90 days, has a chronic or serious illness. Arizona waives the 90 day bare period for an eligible child with a chronic or serious illness

Questions Related to ABD and Medicaid Buy In (i.e., Freedom to Work (FTW)) Programs

We ask the following questions only as needed for persons identified by data sources to be blind or disabled or otherwise not eligible for Medicaid or CHIP on the basis of MAGI.

Past receipt of Supplemental Security Income (SSI Cash)

We ask this question to identify potential eligibility for certain ABD categories.

Potential Disability

We ask if the person has a mental or physical disability that has or will keep him/her from working for at least 12 months to identify potential eligibility for the Aged, Blind, Disabled (ABD) program.

We ask if the person works and has a significant impairment to identify potential eligibility for the Freedom to Work program.

Impairment/Blind Related Work Expenses

We collect eligible expenses only as applicable and needed to complete the eligibility determination

Student Earned Income Exclusion

We collect student status for persons under age 22, disabled or potentially disabled, and having earned income, and otherwise over income for these programs in order to apply the student earned income exclusion.

Court-Ordered Child Support

We collect court-order child support for parents of a disabled or potentially disabled person who is otherwise over income for these programs, in order to apply the child support deduction